



STUDENT MEDICATION REQUEST FORM

This form must be completed for medication to be administered to your child during school hours. It has been designed to ensure the safety of your child and to protect school staff who do not have medical training.

The following points are for security and safety purposes, and are requirements of the *Health (Drug & Poisons) Regulation 1996 (Qld)*

- The parent notifies the school in writing to administer medication. This *may* include written guidelines from the prescribing health practitioner, including potential side effects or adverse reactions.
- Provide medication in **original pharmacy labelled container** to the school.
- Ensure medication is not out of date and has an original pharmacy label with the student's name, dosage and time/s to be taken.
- The student has received a dose at home without ill effects.
- Advise the school in writing and collect the medication when it is no longer required at school.
- A new form is to be completed if the student is prescribed a change in medication, and/or if the regime is re-started after the conclusion date of the initial instructions and/or at the beginning of each new calendar year.

Section 1 is to be completed by you or your child's medical practitioner. **Section 2** is to be completed by you. Please return the completed form to the school.

Where possible, medication should be administered to your child at home at times other than during school hours.

**Section 1
MEDICATION INSTRUCTIONS AS PRESCRIBED BY A MEDICAL PRACTITIONER**

These instructions are as prescribed by the student's medical practitioner to enable the school to maintain its *duty of care* when administering medication to students whose condition would otherwise preclude attendance at school.

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|------------------------------|--|
| Medical Practitioner's Name: | |
| Address: | |
| Name of Student: | |
| Name of Medication: | |
| Dose: | |
| Time to be taken: | |
| Commencement date: | |
| Conclusion date: | |

Special arrangements: (eg. monitoring the student after administration; restrictions on participation in school activities such as sports or use of machinery; side effects; emergency actions.)

**Section 2
NOTIFICATION AND REQUEST BY PARENT/PERSON WITH LEGAL RESPONSIBILITY FOR STUDENT FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS**

I request administration of medication as instructed above for my son/daughter. I understand the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may arise against any school personnel relative to the administration of this medication to my child according to the instructions provided above.

| | | | |
|-----------------------|--|--------|--|
| Full name of student: | | | |
| Date of Birth: | | Grade: | |

Signed: _____ Date: _____
(Parent or person with legal responsibility for the student)

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|------------------|------|--|--------|--|
| Contact details: | Mob: | | Phone: | |
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