Our Lady of the Way Primary School

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Letter of Explanation to Parents
Regarding Request to Administer Medication at School

Date: _____

Dear _____

Please find attached the forms that need to be completed so that medication can be administered to your child during the school day.

These forms have been designed to ensure the safety of your child and to protect the school staff who do not have medical training.

Form 1 is to be completed by you. Form 2 is to be completed by the medical practitioner prescribing the medication. Once completed please return both forms to the school.

I am aware that this may seem a complicated process but please be assured that the school will give you every assistance in this matter.

In this instance, and as an interim measure only, we will undertake to administer medication to your child without the required documentation until _____.

Please do not hesitate to contact me if I can be of further assistance to you.

Yours sincerely,

Sue Veling
Principal

FORM 1

NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

To be completed by parent or guardian

I request that my child be allowed to take medication according to the following medication details:

Student's Name:	
Student's Class:	
Prescribing Doctor's Name:	
Prescribing Doctor's Address:	
Prescribing Doctor's Phone Number:	
Medical Condition Requiring Medication:	
Starting Date of Medication Administration:	
Finishing Date of Medication Administration:	
Name of Medication:	
Dosage:	
Times of Administration:	
Does the medication need to be refrigerated?:	Yes / No
Special Instructions:	

I hereby give permission to the Principal to obtain relevant information from the prescribing doctor. I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medicine.

I hereby indemnify and agree to keep indemnified the Catholic Education Office and its employees and agents, and Our Lady of the Way School and its employees and agents, including the teachers and other staff of the school, from and against all actions, suits, claims, demands, complaints and causes of action (including for or in respect of death, personal injury or any alleged infringement of the rights of any person) and the costs thereof in respect of or arising directly or indirectly out of such administration of medication.

Signed: _____ Date:_____

parent/guardian

FORM 2

MEDICAL ADVICE TO SCHOOL

To be completed by prescribing doctor

Student's full name: _____

1. **Medical Condition(s) of the child requiring regular treatment:**

_____

_____

_____

_____

2. **Recommended restrictions on participation in school activities (e.g. sport, use of tools or machinery)**

_____

_____

3. **Recommended procedure in crisis situation**

_____

_____

_____

4. **Additional comments**

_____

_____

Details Of Essential Medication Requiring Administration During School Hours:

Condition Name:	
Medication Name:	
Dosage:	
Time/s of Administration:	
Special Instructions:	
Self Administration	Yes / No

Signature of prescribing doctor:_____ Date:_____

SCHOOL ACKNOWLEDGEMENT OF REQUEST TO ADMINISTER MEDICATION

Date: _____

Dear _____
(name of parent/guardian)

I have considered your request to administer medication to your child _____
(full name of student)

The school will render whatever aid is necessary to administer the medication, but it should be clearly understood that this aid is that of a lay person without medical training.

To comply with your request, the following conditions should be strictly observed:

1. It is your responsibility to provide the medication and equipment for its administration, and to ensure its immediate replenishment after use, or when it has passed its use-by date.

2. The attached form must be completed before any changes to the medication and its administration can be implemented.

3. I understand that the information provided by you and the prescribing doctor may be discussed by the Principal with other members of the school staff.

Yours sincerely,

Sue Veling
Principal

FORM 3

NOTIFICATION OF CHANGE TO MEDICATION

To be completed by parent/guardian

Student's Name:	
Student's Class:	
Prescribing Doctor's Name:	
Reason for Change of Medication:	
Condition Name:	
Name of Medication:	
Dosage:	
Times of Administration:	
Does the medication need to be refrigerated?:	Yes / No
Special Instructions:	
Self Administration	Yes / No

Signature of Parent/Guardian: _____ Date: _____