Our Lady of Mt Carmel Primary

FORM 1

TO BE COMPLETED BY PARENT/GUARDIAN and returned to School Office

Notification and Request by Parent/Guardian for the Administration of Prescribed Medication during School Hours

I request that my child, ____________________________________ be administered medication at school
(Child's Name)
according to instructions from:

____

Full Name of Prescribing Doctor ____

Address of Prescribing Doctor ____

Contact No ____

The medication has been prescribed for the following reason:

____

____

I hereby give permission to the Principal to obtain relevant information from the Prescribing Doctor.

I accept and agree that it is my responsibility to:

1. Provide the medication and equipment for its administration and to ensure its immediate replenishment after use.
2. Take note and diarise the expiry date of my child's medication to ensure that it remains current.
3. Inform the school in writing of any changes involving the administration of medication at which time new forms will be required to be completed.

____ ____________________

Parent/Guardian Signature *Date*

Our Lady of Mt Carmel Primary

FORM 2
TO BE COMPLETED BY PRESCRIBING DOCTOR
<u>and returned to School Office</u>

Medical Advice to School

Child's Name: ____

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

____

____

Essential medication requiring administration during school hours:

MEDICATION DETAILS					
Condition Name	**Medication Name**	**Dosage**	**Time/s of Admin**	**Special Instructions**	**Self-Admin (YES / NO)**

2. Recommended restrictions on participation in school activities (eg. sport, use of tools or machinery):

____

____

3. Recommended procedure in **CRISIS situation**:

____

____

____

5. Additional Comments:

____

____

____ ____________________

Prescribing Doctor's Signature ***Date***

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