WOOLOOWARE
PUBLIC SCHOOL

REQUEST TO ADMINISTER MEDICATION – SHORT TERM

Child's name:... Class:...

Parent's name:.. Phone:...

Address:...

Doctor's name:.. Phone:...

Address:...

I wish to advise Woolooware Public School that my child has the following **short term** condition / illness:

....

....

Due to this **short term** condition / illness, my child is required to take medication while at school. I request that authorised staff at Woolooware Public School administer the following medication to my child:

Name of medication	Dosage required	Time to be administered	Date start/end

Staff assisted administration of medication ☐ Student self administration of medication ☐

If your child self administers this medication at home, please advise if you authorise your child to self administer this prescribed medication at school: ☐ Yes ☐ No

If your child self administers their medication at home, please indicate the level of support you provide:

....

The following conditions apply to any student receiving medication for a **short term** medical condition:

- ☐ I understand that my child's medication cannot be administered unless this request form is fully completed.
- ☐ I understand it is the **responsibility of my child** to attend the School Office to receive this medication.
- ☐ I understand that I must supply this medication in the exact dosages required by my child.
- ☐ I understand that this medication must be supplied to the School Office by myself or another adult authorised by me.
- ☐ I understand that only authorised Woolooware Public School staff will administer this medication.
- ☐ I understand that Woolooware Public School staff will not take responsibility for measuring any doses of medication.
- ☐ I understand that I need to inform Woolooware Public School staff immediately of any changes to my child's medical condition or any changes in prescribed medication.
- ☐ I understand that the medication must be collected from the School Office by myself or another authorised adult at the end of the school day.

Name of authorised adult collecting medication:..

Any additional information of which Woolooware Public School staff should be aware:

....

....

Signed:.. Date:..

☐ Medication packaging sighted and **copy attached**

School Office Authorisation:.. Date:..

PRIVACY NOTICE

The information requested on this form is essential for assisting Woolooware Public School to plan for the support of your child's health needs. It will be used by the N.S.W Department of Education and Trainng for the development of arrangements with you to support your child's needs. Provision of this information is voluntary. If you do not provide all or any of this information, the school's capacity to support your child's needs could be impaired. This information will be stored securely. You may correct any personal information provided at any time by contacting the Principal.

LEARNING FOR LIFE

Wills Road, Woolooware NSW 2230 | Office: 02 9523 5411 | Email: woolooware-p.school@det.nsw.edu.au

woolooware-p.schools.nsw.gov.au