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Hannans Primary School
striving for excellence

Dear Parent/Carers,

I would like to seek your assistance in establishing a process for managing the administration of medication to students when they are in the school's care. Except in an extreme emergency, e.g. unexpected anaphylaxis, medication can only be administered by school staff if appropriate documentation has been completed by Parents/Carers. This applies to both prescribed and non-prescribed medication.

SHORT TERM USE OF MEDICATION (UP TO TWO WEEKS)

For administration of **short term** medication such as a course of antibiotics, our school requires written authority from parents/carers. This authority can be provided by completing an ***Administration of Medication* form**. These forms can be obtained from the Office or downloaded from the school's website.

Alternatively, parents/carers may complete the attached form and provide the medication to the school.

Note:

- The medication must be clearly labelled with the child's name and provided in packaging from the pharmacy or the manufacturer.
- Documentation must be signed and dated by a parent or carer and provided to the school with the medication.

LONG TERM USE OF MEDICATION

If you require the school to administer medication to your child for a period of more than two weeks, and if you have not already done so, you may need to complete a *Student Health Care Summary* and a *Management/Emergency Response Plan* for your child's particular health need. In most instances, this documentation will have been completed when you enrolled your child or as part of the school's process for updating student health care records. If this is not the case, please discuss with the Deputy Principal or Office Staff.

Thank you for your help.

Yours sincerely

Denyse Delfs
PRINCIPAL

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REQUEST TO ADMINISTER MEDICATION TO MY CHILD WHILE IN THE CARE OF THE SCHOOL

(Note: Medication must be provided by Parents/Carers)

STUDENT'S NAME		
DOB		
FORM/CLASS		
NAME OF MEDICATION		
DOSE/FREQUENCY (MAYBE AS PER PHARMACIST'S LABEL)		
ROUTE OF ADMINISTRATION (E.G. BY MOUTH)		
EXPIRY DATE OF MEDICATION		
DATES Of ADMINISTRATION	**FROM:** **TO:**	
STORAGE REQUIREMENTS: (E.G. REFRIGERATOR)		
NAME OF ADMINISTRATOR:	**Office Staff**	
PARENT/CARER SIGNATURE:		**DATE:**