NSW GOVERNMENT Education

Mary Street, Northmead NSW 2152
Telephone: 9639 7334, 9639 8448, Fax 9686 3471
Email : thehills-s.school@det.nsw.edu.au
www.thehills-s.schools.nsw.edu.au

The Hills School
We Love Learning

Request for schedule for the administration of prescription medication

INTERMITTENT OR REGULAR MEDICATION

Name of student: _____ D.O.B. _____ Date: _____

Medical condition(s) that require intermittent or regular medication and treatment:

_____

_____

What are you requesting the school to do (e.g. Administer medication as per scheduled below)?

_____

_____

If your child requires intermittent treatment, what signs indicate that treatment is required?

_____

_____

Intermittent or regular medication to be administered during school

Any special instructions for administrating above medications?

_____

_____

Condition	Name of Medication	Dosage Method	Frequency	Before/After Meals or N/A

Special storage requirements e.g. Fridge

_____

_____

*Any dietary restrictions or other medication contra-indicated while the child is taking the above medications? Please indicate:

_____

_____

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*Through the information you have obtained (including doctors). Are you aware of any likely side effects from the prescribed medication?

_____

_____

*Any other comments regarding management of child's medical conditions. e.g. restrictions in school activities such as sport?

_____

_____

_____

Seizure / Asthma Management

Time Frame	Treatment	Contact Parents Medical Assistance	Contact Numbers
At onset			

Please list any prescribed medication administered at home:

_____

_____

I hereby give my permission for the necessary information to be supplied to the school and for the school to seek clarification by the doctor if required. I understand that scheduled medication needs to be reviewed each year.

I understand that the information so disclosed may be discussed by the Principal of the school with the others members of the school staff in order to assist the ability of the school to meet my child's medical requirements and that this medication may be administered by designated staff members who may not have medical qualifications.

Privacy notice

The information requested on the form is essential for assisting the school to plan for the support of your child's health needs. It will be used by the NSW Department of Education and Communities for the development of arrangements with you to support your child's health 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 health needs could be impaired. This information will be stored securely. You may correct any personal information provided at any time by contacting the Principal.

Signed: _____ Date: _____

Parent/ Caregiver

Signed: _____

Medical Practitioner Date: _____

Medical Practitioner Contact Details

Review (please sign and date changes and sign below)

Signed: _____ Date: _____

Parent/ Caregiver

Signed: _____ Date: _____

Medical Practitioner

Medical Practitioner Contact Detail