COLWILL SCHOOL

ADMINISTERING MEDICATION POLICY

Rationale
From time to time school staff may be required to administer medication to children. The school should only be requested to administer medication during normal school hours when it is either not possible or impractical for a parent or caregiver to do so.

Purpose
To facilitate the administration of prescribed medicines to ensure that a child's health is not placed in jeopardy by school attendance.

Guidelines
1. The first dose must **not** be given at school.

2. All requests should be on the appropriate parent request form and addressed to the principal.

3. The medication must be kept in a safe place, if possible in the school's administration area, in a child-proof container.

4. The exact dose of medication must be provided by the parent/caregiver to the school.

5. The principal may delegate the administering of medication. School staff will administer prescription medication on a volunteer basis only.

6. The delegated person/s will administer the medication as requested by the parent/caregiver/doctor.

7. Before medication is administered the school will require written confirmation by the parent/caregiver/doctor.

8. Whenever possible administering of medication will be witnessed by another adult and a record of administering initialled by both adults.

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APPROVED BY BOT:	October 1999
REVISED:	6 August 2002
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ADMINISTRATION OF MEDICATION AT COLWILL SCHOOL

Child's Name:_____ Room:_____ Year:____

Date of Birth:_____

Parent/Caregiver Name:_____ Daytime Number:_____

Supervising Doctor:_____ Phone:_____

Permission to contact Doctor if necessary: Yes / No Signed:_____

My child requires the following prescription medication at school:

Name of Medication: _____

Dose: _____

General Instructions: _____

_____

It needs to be taken at: _____ (time)

Start Date: _____ Finish Date: _____

Possible side effects (if any):_____

My child will administer his/her own medication: Yes / No

My child needs supervision when taking his/her medication: Yes / No

My child requires an adult to give the medication: Yes / No

My child is taking this medication because he/she has:

_____ (state condition)

I accept full responsibility for maintaining supplies, having my child's name, the name of the drug and the correct dose on the container, and that the supplies will not have passed the expiry date. I give permission for a member of the school staff to administer the medication according to my child's needs as indicated above and accept that this may not be the same staff member each time. I accept that the school will take due care with the administration of this medication but I release the school and the school's staff from any responsibility associated with it. I will inform the school in writing if there is any change in the above medication information. The school will accept responsibility for keeping this information in a safe place.

Full Name:_____ Signature:_____ Date:_____

Approved by Principal:

Signature: _____ Date: _____