Belong Explore Flourish Serve

Pilgrim School

Medication Plan – Prescription Medication

Confidential

To be completed by the PRESCRIBING DOCTOR and the Parent/Guardian for a child who requires prescription medication during school hours or at a school endorsed avctivity. This information is confidential and will be available only to supervising staff and emergency medical personnel.

To the Doctor

- *Please complete all sections of this form.*
- *Please schedule medication outside school hours wherever possible*
- *Be specific:* ***As needed*** *is* ***not*** *sufficient direction for staff members – they need to know exactly when medication is required. (ie where applicable, please give details for what symptoms, or when medication is to be administered.)*
- *Nominate the simplest method:* ***For example: Oral or 'puffer' medication is much easier to arrange than a nebuliser.***

Please note that education workers:

- *Accept only medication which has been ordered by a doctor and is provided in the original, fully labelled pharmacy container.*
- *Do not administer first dose of a medication or monitor the effects of medication as they have no training to do this.*
- *Require medication to be handed adult to adult.*
- *Are instructed to seek emergency medical assistance if concerned about a child's response or behaviour following medication.*

Name of child ..... Date of Birth .....
Last Name (please print) *First Name (please print)*

Medic Alert number (if relevant) ..... Review Date .....
(Max 12 months)

MEDICATION INSTRUCTIONS (Please print clearly)	
Medication name and form (eg liquid, capsule, ointment)	**Times** (Please indicate times relevant to schooling) ☐ Early morning ☐ Mid-Morning ☐ Middle of the Day ☐ Mid-afternoon ☐ Evening ☐ Other (please specify) ☐ With food ☐ Before food
Dose	
Route (eg oral or inhaled)	
Storage *(eg must the medication be refrigerated?)*	
Any other instructions	

Please note:

- *Students are supervised when they take their medication.*
- *Medications are kept secure in the First Aid Room.*

AUTHORISATION - DOCTOR

Medical Practitioner ..... Role .....

Address .....

..... Telephone .....

Signature ..... Date .....

AUTHORISATION AND RELEASE – PARENT/CAREGIVER

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education staff and emergency medical personnel.

Name ..... Signature ..... Date .....
Parent/Caregiver (please print)