Eschol Park Public School

Eschol Park Drive, Eschol Park NSW 2558
Telephone: 9824 7111
Facsimile: 9820 3046
e-mail: escholpark-p.school@det.nsw.edu.au

Request for children requiring administration of prescribed medication at school

(Note: if your child is to take more than one prescribed medication, please attach a separate request for each medication.)

Please complete this form on the basis of information provided by your medical practitioner and/or pharmacist and return it to the school. Please provide medication in original packaging.

Please advise the school principal at any time if there are changes in the information about your child's health care needs.

Name of child: _____

Roll Class: _____

Scholastic Year: _____

Name of prescribed medication: _____

Prescribed for (name of medical condition):

_____

Prescribed dosage:

_____

What are you requesting the school to do?

_____

_____

Medication

Expiry date of medication: _____

Special storage requirements if any e.g. in refrigerator:

_____

Time medication needs to be taken:

☐ Morning (8:30-9:00) _____ ☐ Recess (11:00-11:30) _____ ☐ Lunch (1:00-2:00) _____

Special instructions for administering the prescribed medication/s e.g. must be taken with food or with a glass of water:

_____

Through information you have from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

Yes ☐ No ☐ If Yes, Please provide more information:

_____

If your child administers his or her own medication at home, do you request that he or she self-administers this medication at school? (Note: The Principal needs to approve a decision for a student to self-administer).

Yes □ No □

If your child self-administers the medication at home, what level of support do you provide? (Please describe):

_____

_____

Name of person who will carry the medication to school: _____

Medical Practitioner Name: _____ Phone: _____

Address: _____

Parent or carer signature: _____ Date: _____

Parent Name: _____