Winston Heights Public School

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SHORT TERM REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION TO THE STUDENT

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

STUDENT'S NAME_____ **CLASS**_____

Name of Prescribed Medication	
Prescribed for: *(Name of medical condition, e.g. asthma Infection etc.)*	
Prescribed dosage	
What are you requesting the school to do? *(e.g. time of administering the medication)*	
Special storage instructions, if any? *(e.g. refrigeration etc.)*	
Special instructions for administering the prescribed medication/s. *(e.g. must be taken with food or a glass of water)*	
Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?	☐ No ☐ Yes – If yes, please provide more information.
If your child administers his or her own medication at home, do you request that he or she administers this medication at school? *(Note: the Principal needs to approve a decision for a student to self administer)*	☐ No ☐ Yes
Name of person who will carry the medication to school	

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 Training 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.

Parent or Carer signature.....**Date**.....