Letter of Explanation to Parents

Dear Parent

Please find attached the forms that need to be completed so that medication can be administered to your child during the school day.

These forms have been designed to ensure the safety of your child and to protect the school staff who do not have medical training.

Form 1 is to be completed by you. Form 2 is to be completed by the medical practitioner prescribing the medication. Once completed please return both forms to the school.

I am aware that this may seem a complicated process but please be assured that the school will give you every assistance in this matter.

In this instance, and as an interim measure only, we will undertake to administer medication to your child without the required documentation until __________.

Please do not hesitate to contact me if I can be of further assistance to you.

Yours sincerely,

Richard Blissenden

Principal
NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Form 1 - To be completed by parent or guardian

I request that my child ____________________________ be allowed to take medication at school according to instructions from ____________________________ (full name of prescribing doctor).

Address of prescribing doctor: ____________________________

Contact number: ____________________________

The medication has been prescribed for the following reason:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I hereby give permission to the Principal to obtain relevant information from the prescribing doctor. I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal of any changes involving the administration of the medicine.

Signed: ____________________________ Date: ______________

parent/guardian
Form 2 - To be completed by prescribing doctor

Student's full name: ____________________________________________________________

1. Medical condition(s) of the child requiring regular treatment:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

2. Essential medication requiring administration during school hours:

Medication Details

<table>
<thead>
<tr>
<th>Condition name</th>
<th>Medication name</th>
<th>Dosage</th>
<th>Time/s of administration</th>
<th>Special instructions</th>
<th>Self-administration (yes/no)</th>
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3. Recommended restrictions on participation in school activities (e.g. sport, use of tools or machinery):

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

4. Recommended procedure in crisis situation

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

5. Additional comments:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Signature of prescribing doctor: __________________________ Date: _____________