MEDICATION PLAN

CONFIDENTIAL

Emmaus CHRISTIAN COLLEGE

To be completed by the **PRESCRIBING DOCTOR** and the **PARENT/GUARDIAN** for a student who requires medication at school. 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.*
- *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 of symptoms.***
- *Nominate the simplest method.*

Please note that Education and First Aid Staff:

- *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 course of medication or monitor the effects of medication as they have no training to this.*
- *Require medication to be handed adult to adult.*
- *Are instructed to seek emergency medical assistance if concerned about a student's response or behaviour following medication.*

Name of Student……..……..……..Date of Birth……..……
Family Name (please print) First Name (please print)

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

MEDICATION INSTRUCTIONS *(please print clearly)*	**TIMES** *(please tick)*
Medication (generic name), strength and form (eg. liquid, capsule, ointment)	☐ Early morning
Dose	☐ Mid-morning
Route *(eg. oral or inhaled)*	☐ Middle of the day
Any other instructions	☐ Mid-afternoon
	☐ Evening
	☐ Other (please specify)

Please note:

- Primary and Middle School Students are supervised when they take their medication.
- Medications are kept secure in the First Aid Room.
- Safe self-management is permitted for Senior Students but only in accordance with school policy (camps excluded).

Please advise if this student's condition creates any difficulties with self-management; for example, difficulty remembering to take medication at a specified time.

AUTHORISATION AND RELEASE

Medical Practitioner……..Professional Role……..

Address……..

……..Telephone……..

Signature……..…Date……..

I have read, understood and agreed with this plan and any attachments indicated above. I approve the release of this information to Education and First Aid Staff as well as Emergency Medical Personnel.

Parent/Guardian……..…Signature……Date……
(Please print name)