FLOREAT PARK PRIMARY SCHOOL
CHANDLER AVENUE, FLOREAT, WESTERN AUSTRALIA 6014
Telephone (08) 9387 1548 Facsimile (08) 9383 7701

Medication Administration POLICY

RATIONALE:
It is preferable for medication to be administered out of school, or by the student himself/herself.

The school Medication Administration policy complies with DET Health Care policy (1).

Where this is not possible, the school's Medication Administration policy aims to put practices in place for safeguarding the health care of all students.

PARENT'S RESPONSIBILITIES:
The following information must accompany a request for assistance:
- The kind of assistance required.
- Advice about the related condition – in particular where emergency authorisation will also be needed.
- Information from the prescribing doctor where the medication has to be administered on a long-term basis.
- The parent must ensure that the medication is clearly labelled, is not out of date and that equipment is in good working order.
- Parents must advise the school of any likely effects which could affect student performance.
- All requests for administration of medication must be written on the form provided.
- For students with medical conditions or health care needs, parents are asked to fill in a *Health Care Authorisation form – see attached*.
- As a reminder, all students are expected to attend school. A reasonable explanation for absence includes sickness, especially when the illness is contagious. If unsure, contact the school admin team.
-

SCHOOL'S RESPONSIBILITY:
- Schools have a responsibility to manage requests for health care assistance.
- The choice of medication is recognised as beyond staff responsibility.
- Individual members of staff may decline to administer prescribed medication or undertake a health care procedure.
- All relevant medical information must be available to those staff who have a student under their care.
- Aspirin must never be administered to students without a medical practitioner's written instruction.
- If it is agreed that medication will be stored by the school, the agreed amount will be handed to the assigned staff member for safe storage. Most prescribed medication will be stored in a lockable compartment or cupboard which can only be accessed by authorised persons. Staff members to record scheduled administration on copy of form – see attached

Reference:
1. DET Health Care Policy

Health Care Authorisation Form

SECTION 1 Student's Personal Details

Student's Name: (surname) ______________________ (other names) ______________________

Date of Birth: _____________________ **Gender:** M / F

Year Level: _______________________ **Class teacher:** _____________________

Medical condition: (name)

____

SECTION 2 Administration of Medication

Name of Medication: ____

Is this prescribed medication: Yes / No Dose ___________________

Expiry date of medication ____/____/____

Commencement date of medication ____/____/____

Conclusion date of medication ____/____/____

Administration instructions (this may be a copy of the pharmacist's label) ____________________

____

Is the student able to self-administer the medication? Yes / No

If not, how will the student be supported by school staff? __________________________________

____

____

Date for review: ____/____/____ For long-term administration of medication the medical practitioner may advise that the medication needs to be reviewed more frequently.

How will the medication be stored if a supply is provided to the school?

Parent Information

I (parent) ______________________ wish to inform the school that my child (name of student) ________________________ will be taking the above mentioned medication whilst at school and request the support of the school as indicated above.

Signed: _______________________

Dated: ____/____/____

SECTION 3 Health care procedures (other than administration of medication) for a student with a long or short-term medical condition

Name of condition ____

What health care procedures are required? ____
____
____

Names of staff responsible for implementation of the procedures? __________________________
____

SECTION 4 Trained staff who will assist a student with medical conditions and/or intensive health care needs

Name of staff member: ____

Position: ____

Health Care procedure: ____

Medical procedure: ____

Training provided by: ____

Retraining due: (if appropriate) ____

Name of staff member: ____

Position: ____

Health Care procedure: ____

Medical procedure: ____

Training provided by: ____

Retraining due: (if appropriate) ____

Review date: ___________________

Address each excursion and/or off school site activity as required in the *Excursions: Off School Site Activities* policy.

SECTION 5 Medical Emergency Plan for

Emergency Contacts

Name: ______________________________ Relationship to student: ____________________________

Phone: ______________________________ Mobile Phone: ___________________________________

Name: ______________________________ Relationship to student: ____________________________

Phone: _____________________________ Mobile Phone: ___________________________________

Emergency Doctor

Name: _______________________________

Address: ____

Phone: _______________________________

Action to be taken in an emergency: ____
____
____

Names of staff responsible for taking action: ____
____
____

Attach additional information to plan if required

Emergency transport requirements: ____
____
____
____
____

In an emergency transport by ambulance will be requested by the principal.
Ambulance cover: Yes / No

Medic Alert number if applicable: _____________________________

Emergency Telephone: _______________________

SECTION 6 Agreement between the school principal, the parent and staff member/s about the student's Health Care Authorisation

Student's Name: ______________________________ Year Level _____________________

Current for the school year: ____

The following signatories agree to participate in the implementation of this Health Care Authorisation which provides for:

- maintaining health of the student during the school day; and
- providing health care for the student in emergency situations.

The agreement authorises the school staff to follow the advice of the student's parents and medical practitioner as set out in the Health Care Authorisation. It is valid only for the year indicated and will need to be updated each year, or earlier if there is a change in the student's health necessitating a change to the Health Care Authorisation.

Signature of Parent Date: ____/____/____

Signature of Parent Date: ____/____/____

Signature of Principal Date: ____/____/____

Signatures of Staff Member(s) Date: ____/____/____

Date: ____/____/____

Date: ____/____/____

Is this Health Care Authorisation to be shared with all staff? Yes / No

If "NO" and the information is to be restricted, who will be informed?

SECTION 7 Treating medical practitioner or health professional information regarding school management of medical conditions and intensive health care needs

Student's Name: ______________________________________Year level: _________________

The information from the medical practitioner or health professional provides instructions to enable the school to maintain duty of care and respond to health care needs during school hours.

Medical condition: ____

Health care procedures:

Health care procedures required and instruction for administration of these procedures:
____
____

Is the student able to manage the procedure independently? Yes ____ No____

If the student can manage independently what support is the school to offer:
____

Administration of medication:

Does the student require the administration of medication during school hours? Yes ____ No____

What is the usual dose for the student? ______________________________

If the medication dosage is to vary, what is the minimum and maximum dosage range that the school can administer?
Minimum: __________________ Maximum:____________________

Symptoms of over dosage and/or over treatment: ____
____
____

When to seek medical assistance for the student: ______________________________________
____
____

I verify that I have read this Health Care Authorisation and agree with the school management described.

Health professional name: ____

Contact details: ____

Signature: _____________________________________ Date: ____/____/____

RECORD OF HEALTH CARE PROCEDURES OR ADMINISTRATION OF MEDICATION

RECORD OF HEALTH CARE PROCEDURES OR ADMINISTRATION OF MEDICATION

STUDENT'S PERSONAL DETAILS

Student's Name (surname) ____________________ (other names)________________________

Date of birth __________________________________ Gender M / F

Year level ____________________________________

RECORD

Date	Time	Procedure / Medication	Staff Member	Signature / Initials