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- The parent must ensure that the medication is clearly labelled, is not out of date and that equipment is in good working order.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

<table>
<thead>
<tr>
<th>Student’s Name: (surname) ______________________ (other names) ______________________</th>
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<tbody>
<tr>
<td>Date of Birth: ______________________________</td>
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<tr>
<td>Gender: M / F</td>
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<tr>
<td>Year Level: ________________________</td>
</tr>
<tr>
<td>Class teacher: ____________________________</td>
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<tr>
<td>Medical condition: (name)</td>
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<td>________________________________________________________________________________</td>
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</table>

## SECTION 2 Administration of Medication

<table>
<thead>
<tr>
<th>Name of Medication: ______________________________________________________________________</th>
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<tbody>
<tr>
<td>Is this prescribed medication: Yes / No</td>
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<tr>
<td>Expiry date of medication</td>
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<td><strong><strong>/</strong></strong>/____</td>
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<tr>
<td>Administration instructions (this may be a copy of the pharmacist’s label) ____________________</td>
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<td>________________________________________________________________________________</td>
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<td>Is the student able to self-administer the medication? Yes / No</td>
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<td>If not, how will the student be supported by school staff? __________________________________</td>
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<td>________________________________________________________________________________</td>
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<tr>
<td>Date for review: <strong><strong>/</strong></strong>/____ For long-term administration of medication the medical practitioner may advise that the medication needs to be reviewed more frequently.</td>
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<tr>
<td>How will the medication be stored if a supply is provided to the school?</td>
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</tbody>
</table>

## 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

## STUDENT'S PERSONAL DETAILS

<table>
<thead>
<tr>
<th>Student's Name (surname)</th>
<th>(other names)</th>
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Date of birth: ____________________  Gender: M / F

Year level: ________________________

## RECORD

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Procedure / Medication</th>
<th>Staff Member</th>
<th>Signature / Initials</th>
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