ADMINISTERING MEDICATION POLICY

Rationale

From time to time school staff may be required to administer medication to children. The school should only be requested to administer medication during normal school hours when it is either not possible or impractical for a parent or caregiver to do so.

Purposes

To facilitate the administration of prescribed medicines to ensure that a child's health is not placed in jeopardy by school attendance.

Guidelines

1. The first dose must **not** be given at school

2. All requests should be on the appropriate parent request form and submitted to the school office.

3. All medication must be kept in the school's administration area, in a child-proof container, and locked away if possible. All medication requiring refrigeration will be kept in a marked container in the fridge in the staffroom.

4. Students who have been prescribed controlled substances will require an Emergency Action Plan (EAP) to be created, describing the required medications, dosages, and any side-effects. All controlled substances will be kept locked away at all times.

5. The exact dose of medication must be provided by the parent/caregiver to the school.

6. The Principal may delegate the administering of medication to another/or other person.

7. The delegated person/s will administer the medication as requested by the parent/caregiver.

8. The school will require confirmation from the student's parent/caregiver before any non-prescription medication is administered.

9. Whenever possible administering of medication will be witnessed by another adult and a record of administering initialled by both adults.

_____
Chairperson, BOT Allandale School

PARENTAL REQUEST FOR ASSISTANCE IN ADMINISTERING DRUGS

Name of Pupil _____

Caregiver's Name _____

Address _____

_____

Contact Phone Numbers Home _____

Daytime _____

Emergency _____

Medical Condition

Supervising Doctor _____

Medication Prescribed _____

Dose _____

I certify that the information given above is correct. I authorise the School to be responsible for the administration of drugs to the above named pupil. I understand that the drugs will be administered by the School Office Manager or in her absence by the Principal or his nominee.

_____ _____

Caregiver's Signature Date

MEDICAL DRUG REGISTER

Pupil: _____

Home Address: _____

Phone Contacts: Home :_____ Daytime:_____Emergency:_____

Medical Practitioner: _____

Condition: _____

Drug Prescribed: _____

Dosage Instructions: _____

Nurse's Comments:

Register of Doses:

Date	Dose	Administered by	Quantity remaining	Comment