Treetops Montessori School

A different approach for Primary and Secondary education from Pre-Kindergarten to Year 12

12 Beenong Road (PO Box 59)
DARLINGTON WA 6070

office@treetops.wa.edu.au
www.treetops.wa.edu.au

(08) 9299 6725

Medication Permission Form

This form must be completed for all medication to be administered to students during school hours. It has been designed to ensure the safety of your child and to protect school staff who do not have medical training. For those students requiring asthma medication, an *Asthma Plan* should be completed instead. For those students requiring anaphylaxis medication, an *ASCIA Action Plan for Anaphylaxis* should be provided instead.

A new form is to be completed if the student is prescribed a change in medication, and/or if the regime is re-started after the conclusion date of the initial instructions and/or the beginning of each new school year.

Student Name: ____

Date of Birth: ______________________________ Year Level: ______________________________

Please Note: wherever possible, medication should be scheduled outside school hours, e.g. medication required 3 times a day is generally not required during a school day: it can be taken before and after school and before bed.

Name of Medication/s:	
Prescribed for: (name of medical condition)	
Prescribing Health Practitioner:	
Dosage (eg: 5ml)	
Route of Administration (eg: oral, by injection)	
Time/s to be taken:	
Storage Instructions:	
Commencement Date:	
Conclusion Date:	
Are there any likely side effects from this medication:? (if yes, please describe)	
Special Arrangements (eg: restriction of activites)	

Medication Delivered to the School

Parent/guardians are to deliver medication to the school administration in a zip-lock bag together with this form. Please ensure:

- Is in its original packaging;
- The pharmacy label matches the information included in this form;
- Is not out of date;
- Is collected when it is no longer required at school. (The school may, at its discretion, dispose of the medication if the conclusion date has passed).

Monitoring Effects of Medication

Please Note: school staff *do not* monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

Self-management of Medication

If your child administers his or her own medication at home, do you request that he/she self-administers at school: N/A ☐ No ☐ Yes ☐

Note: The Principal needs to approve a decision for a student to self-administer.

PARENT/GUARDIAN:

I request administration of medication as instructed above for my child. I understand the school staff cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may arise against any school staff relative to the administration of this medication to my child according the instructions provided above.

Signed: ____________________________________ (Parent/Guardian)

Name: ____________________________________

Date: ____________________________________

Office Use:

RECORD OF ADMINISTRATION OF MEDICATION				
Date	Time	Medication	Staff Member	Signature/Initials

To be retained on the student's file when completed.