



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- The parent must ensure that the medication is clearly labelled, is not out of date and that equipment is in good working order.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

Review date: _____

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: (08) 9334 1234

Review date: _____

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: _____

Review date recommended: _____

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