



St. Joseph's Primary School

LEARNING THROUGH AND IN JESUS CHRIST

DISPENSING MEDICATION

Rational

Arising from the duty of care that St. Joseph's owes to their students, there will be occasions when the administration of medication is necessary to support students during the course of a normal school day or in school activities outside of normal school hours.

While children may require medication for reasons of health, sometimes medication will be necessary to assist learning or to modify behaviour.

It is also important that school staff responsible for administering medication are appropriately inserviced (have current Certification in First Aid, Resuscitation, Anaphylaxis and Asthma), and that staff generally are periodically reminded of the school's policy guidelines for dispensing medication.

It should be noted that the policy guidelines which follow apply only to oral medication.

In the case of antibiotics, common sense dictates that it is not practical to require all Notification/Permission slips be completed. The Principal will use here discretion in this regard.

Administration of Non-Prescribed Medication

- * No medication should be given to a child without the written permission of a parent/guardian except in emergency circumstances when a child presents with asthma symptoms (see Asthma Policy). In exceptional circumstances where telephone permission may be given to a parent such permission must be witnessed and signed by another member of staff on the medication register.
- * Parents are discouraged from providing children with medication at school, unless on Doctors advice.
- * All medication will be kept in the Medication Cupboard in the staff room, in original packaging, clearly labelled with all relevant information for the child for whom it has been provided.
- * Parents will be required at the commencement of each year of St. Joseph's policy in regard to the administration of medication and new dispensing medication forms completed.
- * It is the responsibility of the Principal to ensure that a Medication Register is established and maintained within the school. The Register will provide the following information: date, time, name of student, type of medication, dosage and the signature of the person administering the medication.
- * The Medication Register shall be kept with the Asthma Register in the First Aid cupboard in the Staff Room.

Administration of Prescribed Medication

- * No medication should be given to a child without the written permission of a parent/guardian
- * Parents are discouraged from providing children with medication at school, unless on Doctors advice.
- * Medication must be supplied by parents in the original container, clearly marked with the student's name, the name of the drug, dosage, frequency of administration and prescribing doctor's name.
- * Appropriate equipment for administration, e.g. medication measures will be supplied by parents.

* All prescribed medication must be kept under lock and key in the medication cupboard in the Staff Room.

* Prescribed medication required by students will be accessible to them as and when required both at the school and whilst on excursions, sports days, camps etc.

* The Principal and the Medical Officer will be responsible for the administration of medication in the school. The first point of contact shall be the School Secretary or in her absence the Principal.

* Where possible, no member of the school staff should administer medication to a student unless the nature and dosage of the medication and the identity of the students have been checked by a second adult person, to ensure that the medication is in accordance with the directions given by the student's parent or guardian. Particular attention should be paid to these requirements when students are working outside the usual classroom situation (e.g. whilst on excursion.)

Following is a written procedure for St. Joseph's to ensure that students requiring medication attend at the appropriate time and place for their medication.

* The required medication and instructions are to be handed to the school secretary by the parent or student upon arrival at school.

* The secretary will notify the student and class teacher of required time for medication.

* Any changes occurring to medication dosage or cessation of medication is to be sent to the school secretary in writing or personally by the parent.

* At St. Joseph's, it is the responsibility of the secretary and the class teacher to ensure that all students attend at the appropriate time and place for their medication.

* At St Joseph's, medications will be dispersed to individuals on an individualized basis. Medications are to be locked away between children and only the individual child's medication is to be out when dispensing.

Emergency Action Plan

A separate Action Plan devised by a student's doctor or ASCIA Action Plan should be filled out for those students who may require emergency assistance (e.g. severe asthma attack, epileptic fit). This Action Plan shall be kept in the First Aid cupboard in the Staff Room, the first aid bag and the child's classroom.

All teachers will be adequately trained in the administration of medication in emergency situations where it is known that a student has a particular medical condition or serious allergy.

Our Medical Register will be updated yearly.

Necessary Documentation

Because of the unique issues involved in the area of school medication and the strict nature of the responsibilities of involved adults, it is essential that the following documentation, samples of which are appended, is prepared and kept current.

Other than for short courses of medication parents and or Doctors will be asked to complete the following relevant forms:

- * Letter of Explanation to Parents
- * Medical Action Plan
- * Forms 1 - 8 as specified below

Form 1	Notification and Request by Parent/Guardian for the Administration of Medication During School Hours
Form 2	Medical Advise
Form 3	School Acknowledgement of Request to Administer Medication
Form 4	Notification of Change of Medication.
Form 5	Overnight Excursion Medical Consent Form
Form 6	ASCIA Action Plan Allergic Reaction
Form 7	ASCIA Action Plan Anaphlyaxis
Form 8	Asthma Record

Additionally, a Medication Action Plan should be determined and documented by a student's doctor. This will be kept in the First Aid cupboard in the Staff Room.



ABN 13 842 254 375

St. Joseph's Primary School

Letter of explanation to parents

Dear _____

Please find attached the forms that need to be completed so that medication can be administered to your child during the school day.

These forms have been designed to ensure the safety of your child and to protect the school staff who do not have medical training.

Forms 1 and 2 are to be completed by you. Form 3 is to be completed by the medical practitioner prescribing the medication. Once completed please return all three forms to the school/college.

I am aware that this may seem a complicated process but please be assured that the school/college will give you every assistance in this matter.

In this instance, and as an interim measure only, we will undertake to administer medication to your child without the required documentation until _____ (*date*).

Please do not hesitate to contact me if I can be of further assistance to you.

Yours sincerely,

Principal

Dispensing Medication Procedures St. Joseph's Culcairn

LEARNING THROUGH AND IN JESUS CHRIST

Acting Principal:
Mr Josh Gaynor

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CULCAIRN NSW 2660

Phone: 02 6029 8577 Fax: 02 6029 8827
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St. Joseph's Primary School

NOTIFICATION AND REQUEST BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

To be completed by parent or guardian

I request that my child _____ be allowed to take medication at
school according to instructions from _____ (full name of prescribing doctor) .

Address of prescribing doctor: _____

Contact number:

The medication has been prescribed for the following reason:

I hereby give permission to the principal to obtain relevant information from the prescribing doctor.
I accept and agree to observe the conditions imposed by the school and understand and agree that it is
my responsibility to inform the principal of any changes involving the administration of the medicine.

Signed: _____

parent/guardian

Date: _____



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MEDICAL ADVICE TO SCHOOL

To be completed by prescribing doctor

Student's full name: _____

1. Medical condition(s) of the child requiring regular treatment:

2. Essential medication requiring administration during school/college hours:

Medication Details

Condition name	Medication name	Dosage	Time/s of administration	Special instructions	Self-administration (yes/no)

3. Recommended restrictions on participation in school activities (e.g. sport, use of tools or machinery):

4. Recommended procedure in crisis situation

5. Additional comments:

Signature of prescribing doctor: _____ Date: _____



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SCHOOL/COLLEGE ACKNOWLEDGMENT OF REQUEST TO ADMINISTER MEDICATION

Date _____

Dear _____

I have considered your request to administer medication to your child _____

The school/college will render whatever aid is necessary to administer the medication, but it should be clearly understood that this aid is that of a lay person without medical training.

To comply with your request, the following conditions should be strictly observed:

1. It is your responsibility to provide the medication and equipment for its administration, and to ensure its immediate replenishment after use, or when it requires replacement.
2. The attached form must be completed before any changes to the medication and its administration can be implemented.
3. I understand that the information provided by you and the prescribing doctor may be discussed by the principal with other members of the school staff.

Yours sincerely,

Principal



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St. Joseph's Primary School

NOTIFICATION OF CHANGE TO MEDICATION

To be completed by parent/guardian

Name of student: _____

Name of prescribing doctor: _____

Reason for change: _____

Medication Details

Condition name	Medication name	Dosage	Time/s of administration	Special instructions	Self-administration (yes/no)

Signature of parent/guardian: _____ date: _____



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Consent and Medical Form for School Camps and Other Overnight Excursions

Please Note:

- In completing and signing this form the parent/authorised care giver gives permission for their child to attend the following camp or other overnight excursion; and
- Agrees to provide on this form all necessary medical and personal information that might be required for the duration of the camp; and
- Acknowledges that, although the following information is provided and kept in confidence, it may be necessary to disclose details to a third party should expert medical intervention be assessed as being required.

Excursion Details	Depart:	Return:
Location:		
Description:	, accommodation is multi share, catered.	
Teacher/s in Charge:		

Student Details

Student Name**Year Level****Teacher****Home Address****Date of Birth**

Emergency Contacts	Relationship	Home 'Phone	Work 'Phone	Mobile 'Phone

Child's Doctor**'Phone****Address****Medicare Number****Private Health Fund and Number**

Medical Details

ANY REFERENCE TO ASTHMA OR ALLERGIES WILL REQUIRE YOU TO PROVIDE ADDITIONAL MEDICAL INFORMATION. Forms will be sent home upon completion and receipt of this consent/medical form.

If your child experiences any of the following please tick the box to the right.

Bed Wetting	<input type="checkbox"/>	Any Type of Fit	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	Existing Injury	<input type="checkbox"/>
Dizzy Spell	<input type="checkbox"/>	Sleepwalking	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	Travel Sickness	<input type="checkbox"/>	Skin Sensitivity	<input type="checkbox"/>

If you have indicated ANY of the named conditions or have another condition to add please provide additional information in the box below.

If your child has exhibited an allergic reaction to any of the following please tick the box to the right.

ANY Food	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	Other Drugs	<input type="checkbox"/>	Bites/Stings	<input type="checkbox"/>
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List below any details of any other allergy not already indicated.

Date of last tetanus immunization or booster.

Never Given	<input type="checkbox"/>	Last Given on this Date	<input type="text"/>
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Tablets and Medicines

Is your child currently taking or likely to need to take medication over the duration of the camp?

Yes	<input type="checkbox"/>	You will need to provide circumstances and dosage details on the next page.
No	<input type="checkbox"/>	

Regulations Regarding the Administration of Medications

- *All medicines must be handed to the teacher in charge prior to leaving, with your child's name, the dose to be taken and when it should be taken. (These medicines will be kept by the teacher and distributed as required.) DOSAGES IN EXCESS OF THAT RECOMMENDED BY THE MANUFACTURER WILL NOT BE ADMINISTERED UNLESS ACCOMPANIED BY WRITTEN NOTIFICATION FROM THE CHILD'S PHYSICIAN. STRONG PAIN RELIEF MEDICATIONS CONTAINING IBUPROFEN and/or CODEINE WILL NOT BE ADMINISTERED AT ALL.*
- *Please do not allow your child to keep any medicine while on the camp/excursion.*
- *If it is necessary for the student to carry his/her own medication, e.g. for asthma, it MUST be with the knowledge and permission of both the parent and teacher-in-charge.*

Medication Details.

Any other relevant medical or personal information.

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Please Note

Only students with a designated food allergy, intolerance or cultural requirement will be provided with an alternative menu. A refusal to consume sufficient nutrition on the basis of an aversion to a particular food or foods is not acceptable behaviour.

Consent:

Medical:

In the event of illness or an accident that requires medical attention, I permit Supervising Staff to seek necessary medical attention on behalf of my child and I agree to be responsible for any costs incurred through such action.

I further authorise qualified practitioners to administer anaesthetic if such an eventuality arises.

Participation:

I understand and agree with the activities of and arrangements made for the Excursion. During the Excursion I delegate my authority to the Supervising Staff and/or Instructors involved in the Excursion. Such teachers or instructors may take whatever disciplinary action they deem necessary to ensure the safety, wellbeing and successful conduct of the students as a group and individually.

Expenses:

I agree to my child's returning home if necessary in the event of illness, injury or non-cooperation, and that I might be required to pay any expenses involved or to come and collect my child from the excursion.

I agree to reimburse the school for any wanton damage caused by my child.

Signature of Parent/Guardian. Date

.....

Student Declaration

I agree to observe the rules of the camp and to co-operate with the teachers throughout the excursion.

Signed:

Date:

.....

There are four (3) pages to this medical/consent document.



8 Blair Street,
CULCAIRN. NSW. 2660.

ABN: 13 842 254 375

St. Joseph's Primary School

Phone: 02 6029 8577

Fax: 02 6029 8827

Email: sjcu-info@ww.catholic.edu.au

ASTHMA RECORD 2018

NAME OF STUDENT: _____ Date of Birth: _____

Address: _____

Phone no: _____ Emergency Phone no: _____

DOCTORS NAME: _____ PH: _____

LOCAL DOCTOR: _____ PH: _____

Asthma Management Plan

Does the child tell the carer when he/she needs medication? Yes No

Child's Symptoms (eg cough) _____

Triggers (eg exercise, pollens) _____

MEDICINE: _____

DOSAGE: _____

INSTRUCTIONS IF ATTACK OCCURS:

☐ Standard Asthma First Aid Plan

Step 1: Sit the child upright and remain calm and provide reassurance. Do not leave the child alone.
Step 2: Give 4 puffs of a blue reliever (Airomir, Asmol or Ventolin), one puff at a time, through a spacer device*. Ask the child to take 4 breaths from the spacer after each puff.
Step 3: Wait 4 minutes.
Step 4: If there is little or no improvement, repeat steps 2 and 3. If there is still little or no improvement, call an ambulance immediately (Dial 000). Continue to repeat steps 2 and 3 while waiting for the ambulance.

*Use a blue reliever (Airomir, Asmol or Ventolin) on its own if no spacer is available.

☐ My Child's Asthma First Aid Plan

As written in consultation with my child's doctor.
(Full details must be attached or staff will use the Standard Asthma First Aid Plan)

NB: A NEW ASTHMA RECORD NEEDS TO BE FILLED IN EVERY TIME YOUR CHILD'S CONDITION CHANGES, OR MEDICATION CHANGES. NOTIFICATION BY PHONE IS AT BEST A VERY TEMPORARY MEASURE.

I authorise the staff to follow the preferred Asthma First Aid Plan and assist my child with taking asthma medication should he/she require help. I will notify you in writing if there are any changes to these instructions.
Please contact me if my child requires emergency treatment or if my child regularly has asthma symptoms.

PARENT'S SIGNATURE: _____ DATE: _____