

Thursday, 22 July 2021

Dear Parent/Caregiver,

You have indicated that your child has a health condition that may require support at school or when involved in school activities, for example, a school excursion. While the main role of the school is to provide education, we want to work with you to keep your child healthy and safe at school.

Please complete the attached form *Request for support at school of a student's health condition*, on the basis of information provided by your medical practitioner and return it to me. (You may wish to discuss the information required with the medical practitioner.) The form includes sections where you can request the administration of prescribed medication and/or other assistance.

When I receive your request for support I will need to discuss it with relevant staff and may need to contact you again.

Please advise me at any time if there are changes in the information about your child's health care needs or if I can assist you.

Yours sincerely,

Natalie MacDonald

Principal

****Please ensure this form is completed and returned to the office in order for us to continue administering your child's medication****



Principal: Mrs. Natalie MacDonald
2 Serpentine Rd, Erina Heights NSW 2260
Phone: 02 4367 7608
Email: erinahts-p.school@det.nsw.edu.au
Website: www.erinahts-p.school.nsw.gov.au



Request for Support at School of A Student's Health Condition

This request form includes 4 sections:

1. Student details (page 1)
2. Request for administering prescribed medication (page 2)
3. Request for other support (page 4)
4. Parent and emergency contact details (page 5)

****Please remember to sign and date the form on page 5 before returning it to the school****

First Name:		Last Name:	
DOB:	Enrolled at EHPS?	Yes	No
		Current School if not enrolled:	

Health Condition:

Could your child experience an emergency reaction in relation to this condition?	Yes	No
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Medical Practitioner Information

Doctor's name/medical centre:
Doctor's name/medical centre address:
Doctor's name/medical centre phone number:

Please provide the name, address and phone number of any other doctor or medical specialist who may currently be treating your child.

Allergy/medical condition	Doctor's name	Address	Phone Number

If your child has a documented plan to support any health or medical needs from a previous school or organisation (e.g. preschool, occasional care, etc.) please provide it to the school as an attachment to this form.
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2. Request for administering prescribed medication to the student

Note: if your child is to take more than one prescribed medication, please attach a separate request for each medication.

Name of prescribed medication:	Prescribed for (name of medical condition):
Prescribed dosage:	
Expiry date of the medication:	Special storage requirements if any (e.g. in refrigerator):
Special instructions for administering the prescribed medication/s e.g. must be taken with food or with a glass of water:	

What are you requesting the school to do?

Through information you have obtained from your doctor or got yourself, are you aware of any likely side effects from the prescribed medication?	Yes	No
If yes, please provide more information:		

If your child administers his or her own medication at home, do you request that he or she self-administers this medication at school?	Yes	No
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Note: the Principal needs to approve a decision for a student to self-administer.

If yes, please describe what support your child needs to administer the medication in a non-emergency situation at school. You may like to include information about how you support your child at home to administer their medication.





Secure delivery of prescribed medication is important for the safety of your child as well as for the safety of other students in the school.

Please name the person who will carry the medication to school:

Note: if you are unable to deliver the medication to school, it is advisable that you nominate a responsible person, who is not a school staff member, to transport the medication to the school.

For some medications and some students it can be appropriate for them to carry their own medication to and at school. For example, asthma reliever medication and pancreatic enzymes for cystic fibrosis. If your child is to carry their own medication we want to be able to support this and request some information so that we are well informed.

Note: The school may still need you to provide the school with an additional supply of the medication for storage in central location/s within the school and for use if your child needs the schools help.

Would you like the principal to consider a request for your child to carry their medication?

Yes

No

Note: The Principal needs to approve a decision for a student to carry their own medication at school.

If yes, please describe where and how your child will carry this medication, for example, my child will carry it on their person in a medical pouch or bum bag.

Note: Your child's medication should be clearly labelled with their name.





4. Parent contact details

Name:
Relationship to child:
Address:
Contact Number:
Email Address:

Parent/Caregiver Signature:	Date:
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Privacy notice

The information requested on the form is essential for assisting the school to plan for the support of your child's health needs. It will be used by the NSW Department of Education and Communities for the development of arrangements with you to support your child's health needs. Provision of this information is voluntary. If you do not provide all or any of this information, the school's capacity to support your child's health needs could be impaired. This information will be stored securely. You may correct any personal information provided at any time by contacting the Principal.





Agreement with Principal for Student to Carry Own Medication

To be completed by office staff

The below student has my permission to carry and administer the listed medication.

Student Name:	
DOB:	
SRN:	
Medical Condition:	
Name of Medication:	

Principals Name:

Principals Signature:

Date:

