OUR LADY OF HOPE SCHOOL
ADMINISTRATION OF MEDICATION POLICY

1. RATIONALE/PURPOSE
1.1 Definition
Medication refers to ALL medicines/medication required to be taken for any medical condition, including prescribed and ‘over the counter’ medicines such as Panadol, cough syrups, and other short-term pain/symptom relief.

1.2 Aims and outcomes:
1.2.1 To inform staff and parents of their responsibilities with regard to the administration of legal drugs.
1.2.2 To ensure that only prescribed medication is administered in the correct dosage, by appropriately trained staff (Senior first Aid Certificate) to ensure students’ safety and wellbeing.
1.2.3 To facilitate the ongoing education of students with specific medical conditions in an unbiased and caring manner.
1.2.4 To inform staff of the medication requirements of their students.

1.3 Waiver
Although staff will make all possible endeavours to ensure that the student has the requested medication on time, no responsibility will be taken by the school or its staff for missed medication, given the busy and unpredictable schedules of the school day.

2. SCOPE
This policy applies to all medicines/medications and all staff, students, parents, caregivers and volunteers in the Our Lady of Hope School community.

3. PROCEDURE
3.1 Medicines at school
3.1.1 It is a legal stipulation that School staff are not permitted to give medication to students unless:
   o The student’s medical condition is such that ongoing medication is required to enable the student to attend school AND
   o Written directions stipulating the administration of the prescribed drugs are provided by the student’s medical practitioner.
   o The staff member must agree to administer medication (ie a voluntary act rather than a prescribed role). The Front Office staff normally administer all medication at Our Lady of Hope School.

3.1.2 If students bring medication to school (apart from asthma puffers, which the student may need to keep), this must be given to the school office for safekeeping, together with a Medical Plan from your medical practitioner (please see Front Office staff). **Medication must not be left in school bags, as this poses a potential risk to other students.**

3.1.3 Teaching staff are not responsible for students’ medication.
3.1.4 Our Lady of Hope bears no responsibility for medication at school being out of date. It is the parent’s responsibility to ensure medication has not expired.
3.1 Procedure continued

3.1.5 School staff will not administer medication that is out of date. Where it is discovered that a student’s medication is out of date, school staff will advise the students’ parents.

3.1.6 No antibiotics are to be given at school. (For medication that needs to be taken 3 times per day, the second dose can be taken at home at the end of the school day - if you have any concerns, please consult your medical practitioner).
  o Exception: For prescribed medication 4 or more times per day, a prescription and/or Doctor's letter must be provided indicating that the student must have a dosage of prescribed medication during the school day.
  o Students who are prescribed antibiotics are expected to remain away from school for at least 24 hours after commencing antibiotics (unless your Dr provides a letter stating that the student is not contagious).

3.1.7 No drops or creams will be administered, only drugs that are taken by mouth, in tablet, liquid form or inhaled.

3.1.8 ‘Over the counter’ medication is not to be administered by school staff (eg cough syrup – if the child is ill, then the child should not be at school, spreading infection).

3.1.9 Where possible and appropriate, first aid staff will oversight and supervise the self-administration of drugs, e.g. Asthma puffer or inhaler.

3.2 Ongoing/Long Term Medication Required to Attend School:

3.2.1 If an ongoing medical condition requiring medication is identified or when long term medication is required to enable a student to attend school, a Medication Plan and any specific care plan (see Appendices 1 to 6) are sent home to be completed by the student's medical practitioner and returned by parent/caregivers. Appendix 7 is to be completed by parent. Medication must be prescribed by a medical practitioner (Doctor) and provided in the original container bearing the child’s name and within the expiry date of the product.

3.2.2 Medication provided from home is stored in a locked cupboard or refrigerator and the school will maintain a register of medication kept at school.

3.2.3 Medication administered is recorded with time, date and signed by First Aider.

3.2.4 Parents are responsible for ensuring that adequate supplies of medication are available at school. Admin staff will endeavour to contact parents when medication supply is running low.

3.2.5 Children refusing to take medication are to remain in the office, parent/s to be contacted, and child is NOT to return to class until medication is taken.

3.3 Short term medication

3.3.1 Panadol and other short term medication is not given to students unless prescribed by a medical practitioner with a medication action plan from the doctor and the medication must be provided by parents/caregivers.

3.3.2 Dosage will be administered in accordance with the prescription and recorded with the time, date and signed by the First Aider.
3.4 Parent Responsibilities

3.4.1 For each new prescription, Medication must refer to the student in question, be in its original container and prescribed by a medical practitioner.

3.4.2 Students who have been sick the previous night or in the morning should be kept home and cared for to prevent further spread of illness.

3.4.3 Parents are responsible for the collection of medication at the end of each School year and returning it at the start of the following School year with an updated copy of a medical care plan (see Appendix 1-6) from the student’s medical practitioner (A reminder letter and new medical forms will be sent home early in Term 4 of each school year. Medication will not be accepted at the start of the school year unless a new medication plan has been provided by the medical practitioner.

3.4.4 Parents are responsible for noting the use by dates of any medication provided to the School and to update the medication when required.

ATTACHMENTS

Appendix 1 Asthma Care Plan
Appendix 2 Anaphylaxis (severe allergy) care plan
Appendix 3 Medication Plan (general)
Appendix 4 Epilepsy and seizure care plan
Appendix 5 Diabetes care plan
Appendix 6 General health information
Appendix 7 Authority to Administer Medication

REVIEW
Reviewed: September 2012
Next review: September 2015

Chairperson

Date

Principal

Date
Asthma care plan
for schools, preschools and childcare services

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN/ADULT STUDENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student: ................................................................. Date of birth: .................................................................
                     Family name (please print) First name (please print)

Medic Alert number (if relevant): ................................................................. Review date: .................................................................

Description of the condition

Signs and symptoms: Frequency and severity:

☐ Difficulty breathing  ☐ Frequently (more than 5 x per year)
☐ Wheeze  ☐ Occasionally (less than 5 x per year)
☐ Tightness of chest  ☐ Daily/most days
☐ Cough  ☐ Other (please specify) .................................................................

Triggers (eg exercise, chalk dust, animals, food, pollens, chemicals, weather, grasses, lawn mowing) .................................................................

Curriculum considerations (eg physical activity, camps, excursions, kitchen, laboratory or workshop activities, interrupted attendance) .................................................................

First aid

If a child/student has an asthma attack at school/preschool/childcare, staff will administer basic asthma first aid:
Assess Is it mild, moderate or severe?
Sit Upright, stay calm and reassure
Treat 4 separate puffs of blue/grey reliever medication with a spacer if available. Repeat in 4 minutes if no improvement.
Help Call for an ambulance if no improvement or when in doubt.
Monitor Observe person. Repeat medication every 4 minutes as required.
All OK Resume activity if free of symptoms. STOP activity if treatment was repeated or symptoms persist.

If you anticipate this child/student will require something other than this standard first aid response, please provide detailed written recommendations so special arrangements can be negotiated.

Additional information attached to this care plan

☐ Medication plan (if supervision of medication is recommended at school/preschool or childcare)
☐ Individual first aid plan (if different to standard first aid—see model over page)
☐ General information about this child/student’s condition
☐ Other (please specify) .................................................................

AUTHORISATION AND RELEASE

Medical practitioner: ................................................................. Professional role: .................................................................
Address: .................................................................................................................. Telephone: .................................................................

Signature: ................................................................. Date: .................................................................

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education/childcare staff and emergency medical personnel.

Parent/guardian or adult student: ................................................................. Signature: ................................................................. Date: .................................................................
                     Family name (please print) First name (please print)
Asthma first aid plan
for schools, preschools and childcare services

Sit person up
Reassure
Stay with person

Give blue/grey reliever puffer
4 puffs via spacer

ASTHMA RELIEVED

ASTHMA PERSISTS
after 4 minutes

REPEAT RELIEVER
4 puffs
via spacer

RELIEF

STOP TREATMENT

Observe

Resume activity

CALL AMBULANCE

REPEAT RELIEVER
4 puffs via spacer
every 4 minutes
until help arrives

NO RELIEF

STOP TREATMENT

Cease physical activity

Observe

INFORM EMERGENCY CONTACTS

INFORM EMERGENCY CONTACTS

SEVERE BREATHING PROBLEMS
Person looks blue

INFORM EMERGENCY CONTACTS
Anaphylaxis (severe allergy) Care plan
for schools, preschools and childcare services

CONFIDENTIAL
To be completed by the DOCTOR and the PARENT/GUARDIAN/ADULT STUDENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student .................................................. Date of birth ................................

Family name (please print) First name (please print)

Medic Alert number (if relevant) .................................... Review date ................................

Description of the condition
Previous observable signs and symptoms:
 □ Presence of known allergen □ Difficulty breathing □ Difficulty swallowing
 □ Swelling of lips, face or body □ Loss of consciousness □ Noisy breathing (wheeze or stridor)
 □ Cough □ Generalised skin rash □ Difficulty talking

Known and suspected triggers: ...........................................

First aid
If a child/student shows any of the above observable signs and symptoms, staff will administer basic first aid:

Call an ambulance
Remove allergen if bee venom, brush or scrape away barb, being careful not to break sac.
if food, empty and rinse mouth. Do not induce vomiting.

Maintain □ A □ B □ C

If you anticipate this child/student will require anything other than this standard first aid response, please provide detailed written recommendations. Education and childcare workers will use this plan to discuss with families how support can be provided in line with the capacities of their service.

Additional information attached to this care plan
 □ Medication plan (if supervision of medication is recommended at school, preschool or childcare)
 □ Individual first aid plan (see model over page)
 □ General information about this child/student’s condition
 □ Other (please specify) ...............................................................

AUTORISATION AND RELEASE

Medical practitioner .................................................. Professional role ................................

Address ........................................................................... Telephone ................................

................................................................. Date ................................

Signature ................................................................. Date ................................

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education/childcare staff and emergency medical personnel.

Parent/guardian
or adult student .................................................. Signature ...........................................

Family name (please print) First name (please print)
# Anaphylaxis (severe allergy) first aid plan
for schools, preschools and childcare services

**CONFIDENTIAL**

<table>
<thead>
<tr>
<th>Name of child/student:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medic Alert number (if relevant):</td>
<td>Review date:</td>
</tr>
</tbody>
</table>

**Exposure or suspected exposure to trigger**
- Seek emergency medical treatment

**Are the following signs or symptoms present?**

<table>
<thead>
<tr>
<th>No signs or symptoms—completely well</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Remove trigger</td>
</tr>
<tr>
<td></td>
<td>Watch for further symptoms</td>
</tr>
<tr>
<td></td>
<td>Give prescribed medication (specified by doctor)</td>
</tr>
</tbody>
</table>

**OR**

<table>
<thead>
<tr>
<th>Skin rash which is red raised and itchy—child/student otherwise completely well</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Remove trigger</td>
</tr>
<tr>
<td></td>
<td>Watch for further symptoms</td>
</tr>
<tr>
<td></td>
<td>Give prescribed medication (specified by doctor)</td>
</tr>
</tbody>
</table>

**OR**

<table>
<thead>
<tr>
<th>Swelling of the lips, face or body OR Cough OR Noisy breathing (wheeze or stridor) OR Hoarse voice OR Difficulty breathing OR Difficulty swallowing OR Difficulty talking</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Remove trigger</td>
</tr>
<tr>
<td></td>
<td>Watch for further symptoms</td>
</tr>
<tr>
<td></td>
<td>Give prescribed medication (specified by doctor)</td>
</tr>
</tbody>
</table>

**OR**

<table>
<thead>
<tr>
<th>Loss of consciousness OR No breathing OR No carotid pulse</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Remove trigger</td>
</tr>
<tr>
<td></td>
<td>Watch for further symptoms</td>
</tr>
<tr>
<td></td>
<td>Give prescribed medication (specified by doctor)</td>
</tr>
</tbody>
</table>

**Monitor:**
- **A** irway
- **B**reathing
- **C**irculation

**AUTHORISATION AND RELEASE**

<table>
<thead>
<tr>
<th>Medical practitioner:</th>
<th>Professional role:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Telephone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

I have read, understood and agreed with this plan and any attachments indicated above. I approve the release of this information to education/childcare staff and emergency medical personnel.

Parent/guardian or adult student: | Signature: | Date: |

Family name (please print) | First name (please print)
## Medication Plan
for schools, preschools and childcare services

**CONFIDENTIAL**

To be completed by the PREScribing DOCTOR and the PARENT/GUARDIAN/ADULT STUDENT for a child or student who requires supervision of medication at school, preschool or while in sessional care.

This information is confidential and will be available only to supervising staff and emergency medical personnel.

### To the doctor

Please:
- Complete all sections of this form.
- Schedule medication outside care/school hours wherever possible.
- Be specific. As needed is not sufficient direction for staff members—they need to know exactly when medication is required.
- Nominate the simplest method. For example, oral or 'puffer' medication is much easier to arrange than a nebuleser.

Please note that education and childcare workers:
- accept only medication which has been ordered by a doctor and is provided in the original, fully labelled pharmacy container
- do not monitor the effects of medication as they have no training to do this
- are instructed to seek emergency medical assistance if concerned about a child/student's behaviour following medication.

---

**Name of child/student**

**Date of birth**

**Family name (please print)**

**First name (please print)**

**Medic Alert number (if relevant)**

**Review date**

---

### Medication Instructions

(Please print clearly)

**Medication name and form (eg liquid, capsule, ointment)**

**Dose**

**Route (eg oral or inhaled)**

**Any other instruction**

---

### Time

(Please indicate times relevant to schooling/child care)

- Early morning
- Mid-morning
- Middle of the day
- Mid-afternoon
- Evening
- Other (please specify)

---

**Please note:**
- Young children (eg junior primary age) are generally supervised when they take their oral/puffer medication.
- Wherever possible, safe self-management is encouraged.

Please advise if this child/student's condition creates any difficulties with self-management; for example, difficulty remembering to take medication at a specified time or difficulties coordinating equipment (eg puffer and spacer).

---

### Authorisation and Release

**Medical practitioner**

**Professional role**

**Address**

**Telephone**

**Signature**

**Date**

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education/childcare staff and emergency medical personnel.

**Parent/guardian**

**or adult student**

**Signature**

**Date**

**Family name (please print)**

**First name (please print)**
# Education and childcare medication log

This form is designed to be used by staff to record their observations of children/students taking routine medication. It should be kept with the child's/student's medication plan.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Tick when checked</th>
<th>Observations/comments</th>
<th>Name (printed and initialed) of person making entry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Right child</td>
<td>Right medication</td>
<td>Right dose (oral/inhaled)</td>
</tr>
</tbody>
</table>
# Epilepsy and seizure care plan
for schools, preschools and childcare services

**CONFIDENTIAL**

To be completed by the DOCTOR and the PARENT/GUARDIAN/ADULT STUDENT.

This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student: ................................................................. Date of birth: .................................................................

Family name (please print)  First name (please print)

Medic Alert number (if relevant): ........................................... Review date: .................................................................

---

### Description of usual seizure activity

Does the child/student have warning signs of seizure onset (e.g. sensations)?

- [ ] Not known
- [ ] Yes
- [ ] No

*If yes, please describe.*

---

Are there any known factors likely to trigger a seizure (e.g. illness, elevated temperature, flashing lights)? *If yes, please describe.*

- [ ] Not known
- [ ] Yes
- [ ] No

---

How long has the child/student been experiencing seizure activity?

---

How often does the child/student experience seizure activity?

---

How long since the last seizure?

---

### Most common seizure activity

<table>
<thead>
<tr>
<th>Observable signs</th>
<th>Recovery time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please describe seizure activity, including characteristics and timelines.</td>
<td>(as when ready to resume normal activities) Please describe typical recovery, including detail of typical behaviour and timeframe.</td>
</tr>
<tr>
<td>Twitching</td>
<td>No loss of consciousness</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Bluiness of lips</td>
</tr>
<tr>
<td>Jerking</td>
<td>Breathing complications</td>
</tr>
<tr>
<td>Eyes stare</td>
<td>Other</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>.............. Seconds</td>
<td></td>
</tr>
<tr>
<td>.............. Minutes</td>
<td></td>
</tr>
<tr>
<td>Slow, needing to sleep afterwards</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

### Other seizure activity

<table>
<thead>
<tr>
<th>Observable signs</th>
<th>Recovery time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please describe seizure activity, including characteristics and timelines.</td>
<td>(as when ready to resume normal activities) Please describe typical recovery, including detail of typical behaviour and timeframe.</td>
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</tr>
<tr>
<td>.............. Seconds</td>
<td></td>
</tr>
<tr>
<td>.............. Minutes</td>
<td></td>
</tr>
<tr>
<td>Slow, needing to sleep afterwards</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
First aid

Note
Call
Call
Protect
Do not
Do not
Monitor
Roll gently
Observe and maintain

time of seizure onset.
an ambulance immediately if you suspect breathing difficulty or injury.
an ambulance if seizure activity continues for 3 minutes (child), 5 minutes (adult).
from injury.
restrict movement but remove objects which may cause harm.
attempt to put anything in the mouth.
the airway: support the jaw to keep the airway open, if needed.
onto side (recovery position) as soon as able. If the person is in a wheelchair, make them comfortable in the chair.

Airway Breathing Circulation (ABC) during recovery.

Child/student needs

Please provide comment on the child/student's emotional response to his or her seizure activity and how best to support him or her during and after a seizure.

Additional information attached to this care plan

☐ Medication plan (If supervision of medication is recommended at school/preschool/child care)
☐ Individual emergency plan (If different to standard first aid–see model over page)
☐ Observation/seizure log for completion by staff (Please specify how frequently this is requested)

☐ General information about this child/student's condition
☐ Other (please specify)

AUTHORISATION AND RELEASE

Medical practitioner ........................................ Professional role ........................................
Address ......................................................................................................................... Telephone ........................................
Signature .......................................... Date ........................................

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education/childcare staff and emergency medical personnel.

Parent/guardian or adult student ........................................ Signature ........................................ Date ........................................

Family name (please print) First name (please print)
**Diabetes care plan**

for schools, preschools and childcare services

**CONFIDENTIAL**

To be completed by the RELEVANT DIABETES SPECIALIST and the PARENT/GUARDIAN/ADULT STUDENT. This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student.................................................................Date of birth ...................................................

Family name (please print) First name (please print)

Medic Alert number (if relevant)...................................................Review date ...........................................

---

**Routine supervision for safety**

Staff members routinely support safe diabetes self-management in the following ways:

- Ensure supervising staff know of the child/student’s diabetes and his or her routine and emergency support plans
- Encourage, in consultation with the child/student, a supportive buddy system with peers
- Enable the child/student to eat at additional times, especially in relation to physical activity
- Enable ready access to the toilet
- Ensure supervision if unwell
- Ensure privacy if testing for blood glucose levels/injecting of insulin is required at school
- Provide a written log, as requested, of any ‘hypos’ and the action taken while supervised by education/care staff.

**Individual routine support needs**

Is this child/student usually able to self-manage his or her diabetes care?

☐ Yes ☐ No

If no, please detail assistance requested from staff to support safety and developing self-management.

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If staff or the child/student is concerned, emergency contact(s) will be informed. A health professional may be nominated by the family to be an emergency contact person as relevant. Please nominate emergency contact and any different/additional steps in relation to this child/student’s management.
**First aid**

**Observable signs of hypoglycaemia (a ‘hypo’) — low blood glucose**

A ‘hypo’ can be caused by too much insulin, not enough food or a missed meal and unplanned or unusual exercise. The signs can progress from mild to severe.

*Treatment is needed promptly to prevent a mild ‘hypo’ from progressing to a severe ‘hypo’.*

<table>
<thead>
<tr>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Sweating, painless, trembling, hunger, weakness</td>
<td>▪ Inability to help oneself</td>
<td>▪ Inability to stand</td>
</tr>
<tr>
<td>▪ Changes in mood and behaviour (e.g., crying, argumentative outbursts, aggressiveness)</td>
<td>▪ Glazed expression</td>
<td>▪ Inability to respond to instructions</td>
</tr>
<tr>
<td>▪ Inability to think straight, lack of coordination</td>
<td>▪ Being disoriented, unaware or seemingly intoxicated</td>
<td>▪ Extreme disorientation</td>
</tr>
<tr>
<td></td>
<td>▪ Inability to drink and swallow without much encouragement</td>
<td>▪ Inability to drink and swallow (leading to danger of inhaling food into lungs)</td>
</tr>
<tr>
<td></td>
<td>▪ Headache, abdominal pain or nausea</td>
<td>▪ Unconsciousness or seizures (jerking or twitching of face, body or limbs)</td>
</tr>
</tbody>
</table>

**FIRST AID in response to these observable signs of low blood glucose**

Give sugar immediately to raise blood sugar level (e.g., half a can of normal — with sugar—soft or fruit drink, or 5-6 jellybeans).

Wait 5 minutes.

If no improvement repeat soft drink/jelly beans and wait further 5 minutes.

If condition improves follow up with a snack of one piece of fruit or one slice of bread or dried biscuits only when recovered (usually 5 minutes).

If still no improvement call ambulance. State clearly that the person has diabetes, and whether he or she is conscious. Inform emergency contacts.

If unconscious maintain Airway Breathing Circulation (ABC) while awaiting ambulance.

Can this child/student usually tell that he or she is developing a ‘hypo’? □ Yes □ No

*If yes, please detail how early he or she is likely to recognise the ‘hypo’ and the action he or she typically takes.*

---

**Observable signs of hyperglycaemia — high blood glucose**

Hyperglycaemia (high blood glucose levels) can be caused by insufficient insulin, too much food, common illness (e.g., a cold) and stress.

Signs for this condition emerge over two to three days and can include:

- Frequent urination
- Weight loss
- Change in behaviour (usually irritability)
- Excessive thirst
- Lethargy

**FIRST AID in response to these observable signs of high blood sugar levels**

Staff members often become aware of these signs when the child/student is constantly going to the toilet.

Emergency contacts should be informed if these signs are observed.

An ambulance should be called immediately if any of the following is observed:

- Rapid, laboured breathing
- Abdominal pains
- Vomiting
- Flushed cheeks
- Sweet acetone smell to the breath
- Severe dehydration

If you anticipate this child/student will require something other than this standard first aid response, please provide detailed written recommendations so individual care arrangements can be discussed with staff.
Treatment

Will any visiting/consulting nurses be supporting this child/student?

☐ Yes  ☐ No

(if yes, please provide details)

---

Additional information attached to this care plan

☐ General information about this child/student's condition
☐ Additional individual care information
☐ Other (please specify)

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AUTHORISATION AND RELEASE

Diabetes specialist ................................................ Professional role .........................................

Name of agency/address .................................................................

................................................ Telephone ........................................

Signature ................................................ Date  .........................

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education/childcare staff and emergency medical personnel.

Parent/guardian
or adult student ................................................ Signature ........................................... Date  .........................

Family name (please print)  First name (please print)
General health information
for schools, preschools and childcare services

CONFIDENTIAL

To be completed by the TREATING HEALTH PROFESSIONAL (general practitioner, psychiatrist, psychologist) and the PARENT/GUARDIAN/ADULT/STUDENT for a child/student requiring additional care/supervision related to his or her general mental health and well-being. Other forms are available for more specific health care plans.

Name of child/student: .................................................. Date of birth ........................................

Family name (please print)  First name (please print)

Medic Alert number (if relevant) ........................................ Review date ........................................

Description of the condition

It is not necessary to provide a full medical history. Staff members need to know information relevant only to the child/student’s attendance, learning and care at the school/preschool/child care.

Management issues for education or childcare service

Please include only information that education and childcare staff will need to teach and care for the child/student, for example:

☐ Impact on capacity to attend and participate in routine learning activities
☐ Limitations on physical activity
☐ Need for rest/privacy

☐ Need for additional emotional support
☐ Behaviour management plan
☐ Considerations necessary for camps, excursions

Please provide details: ..............................................................
General health information (cont)

Additional information

☐ Further information regarding this child/student's condition and care needs

☐ Other (please specify)


AUTHORISATION AND RELEASE

Health professional ......................................................... Professional role ................................

Address ...................................................................................................................

............................................................................................................................ Telephone ................................

Signature ................................................................. Date ................................

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education/childcare staff and emergency medical personnel.

Parent/guardian
or adult student ........................................ Signature ................................ Date ................................

Family name (please print)  First name (please print)
AUTHORITY TO ADMINISTER PRESCRIBED MEDICATION TO STUDENT AT SCHOOL
(A SEPARATE FORM MUST BE COMPLETED FOR EACH STUDENT AND MEDICATION)

NAME OF STUDENT: ........................................

TEACHER: ......................................................

NAME OF MEDICATION: ........................................

PRESCRIBING DOCTOR: ........................................

START DATE: ...... END DATE: ..... USE BY DATE ON MEDICATION: ............

(Parents are responsible for noting use by dates and updating medication)

QUANTITY PROVIDED TO SCHOOL (MLS/TABLETS): ..............................

DOSAGE: ..........................................................

WHEN TO BE TAKEN: ........................................

FREQUENCY: ...................................................

POSSIBLE SIDE EFFECTS: ......................................

ANY OTHER RELEVANT INFORMATION: ...........................................

.................................................................

WAIVER: The school will make all possible endeavours to ensure that the student has the requested medication on time however no responsibility will be taken by school staff for missed medication given the busy and unpredictable schedules of the school day.

PARENT / GUARDIAN SIGNATURE: ........................................
DATE: .............................................................