



ST JOHN FISHER CATHOLIC SCHOOL

Medication Policy

POLICY STATEMENT

The vision for our school is to make St John Fisher:-

“ A Christ – centred community in which Gospel values are evident, learned and lived. A place where the individuality of all is nurtured and respected.”

This policy is designed to provide guidelines for the distribution of medication. This policy is applicable to all forms of medication that have to be administered.

STATEMENT OF PURPOSE

- to provide guidelines for the distribution of medicine;
- to ensure both the safety of the child and to protect the school staff who do not have medical training; and
- to inform all staff of children suffering from ongoing medical conditions.

MEASURABLE OUTCOMES

- accurate and up to date paperwork is kept in the Secretary's office;
- administration of medicine takes place at the appropriate time;
- procedures are in place for the distribution of medication;
- procedures are in place for distribution of medication when office staff are not on the school premises;
- **a display of child photo and relevant medical information in the staff room.**

REQUIRED REGULATIONS

- completion of all necessary forms (Appendixes one to seven);
- guidelines for distribution of medicine (Appendix 8);
- provision of a current photo and medical information to be provided by child's family. (Appendix 9)

REFERENCES

- Policies ; Asthma Management Policy.

EVALUATION

The policy and its accompanying procedures will be reviewed at the beginning of each school year.

MEDICATION APPENDIX 1

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:

Full name of Child

Be allowed to take medication at school according to instruction from:

Full name of Prescribing Doctor

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. I agree to indemnify the School and related parties on the terms of the attached **Deed of Indemnity**.

Signed: _____
Parent / Guardian (1)

Date: _____

Signed: _____
Parent / Guardian (2)

Date: _____

MEDICATION APPENDIX 2

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

To: _____
Name of Prescribing Doctor

I: _____
Parent / Guardian

Give permission for the release of information to the Principal of:

Name of School

Concerning medication currently prescribed for my child:

Full name of Child

I understand that the information provided by you may be discussed by the Principal with other members of the school staff.

Signed: _____
Parent / Guardian

Date: _____

MEDICATION APPENDIX 3

REQUEST TO PRESCRIBING DOCTOR FOR MEDICAL DETAILS
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Dear: _____
Name of Prescribing Doctor

Initial and surname of Parent / Guardian

of: _____
Address

Has informed me that their child:

Full name of Child

requires the administration of medication during school hours.

Please complete the details on the form attached (**Appendix 4**) to assist the school staff to ensure that the child named above receives the necessary attention.

You will note (see attached **Appendix 2**) that the parent / guardian has given permission for the information to be released.

Yours Sincerely

Signed: _____
Principal

Date: _____

MEDICATION APPENDIX 4

MEDICAL ADVICE TO SCHOOL

To be completed by Prescribing Doctor

Child's full name:

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

A: _____

B: _____

C: _____

2. Medical condition(s) of the child requiring occasional treatment:

D: _____

E: _____

F: _____

3. Signs indicating occasional need for the administration of medication:

4. Essential medication requiring administration during school hours:

Medication Details					
Condition name	Medication name	Dosage	Time/s of admin	Special instructions	Self admin Yes / no

MEDICATION APPENDIX 5

DEED OF INDEMNITY

In consideration of the members of staff of St John Fisher Catholic Primary School at my/our request administering medication to my/our son/daughter _____ I/we hereby indemnify and agree to keep indemnified the Catholic Schools Office and its employees and agents, and St John Fisher Catholic Primary School and its employees and agents, including the teachers and other staff of the school, from and against all actions, suits, claims, demands, complaints and causes of action (including for or in respect of death, personal injury or any alleged infringement of the rights of any person) and the costs thereof in respect of or arising directly or indirectly out of such administration of medication.

Signed, sealed and delivered by the said: _____

Parent / Guardian (1)

In the presence of: _____

Signature of witness

Name of Witness (please print)

Signed, sealed and delivered by the said: _____

Parent / Guardian (2)

In the presence of: _____

Signature of witness

Name of Witness (please print)

MEDICATION APPENDIX 6

SCHOOL ACKNOWLEDGMENT OF REQUEST TO ADMINISTER MEDICATION
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Dear: _____
Name of Parent / Guardian

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

Full name of Child

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

To comply with your request, the following conditions must 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 (appendix 7) must be completed before any changes to the medication and its administration can be implemented.

Yours Sincerely

Signed: _____
Principal

Date: _____

MEDICATION APPENDIX 7

NOTIFICATION OF CHANGE TO MEDICATION

To be completed by Parent / Guardian

Name of Child: _____

Name of Prescribing Doctor: _____

Reason for change: _____

Medication Details					
Condition name	Medication name	Dosage	Time/s of admin	Special instructions	Self admin Yes / no

Signed: _____
Parent / Guardian (1)

Date: _____

Signed: _____
Parent / Guardian (2)

Date: _____

MEDICATION APPENDIX 8

GUIDELINES FOR THE DISTRIBUTION OF MEDICATION

- all relevant paperwork (Appendixes 1-7) must be completed and filed;
- medication in original dispensary packaging to be stored in the Sick Bay, in the medicine drawer, which is kept locked at all times;
- other medication that requires refrigeration is to be kept in the staffroom fridge;
- timetable for the distribution of medication which requires administration over a long period of time is to be fixed inside the Medicine drawer;
- office Staff to administer medication; and
- in the absence of Office Staff the Assistant Principal or his/her designated teacher is to follow the requirements for the distribution of medication.

MEDICATION APPENDIX 9

Dear Parents,

To provide appropriate care for your child we need a current photograph as well as the following information regarding your child's specific medical condition:

Name of condition: _____

Current medication: _____

Emergency contact number: _____

Any other relevant information: _____
