Valentine Public School
Tallawalla Road, Valentine NSW, 2280 Ph: 0249 428 211
Email: valentine-p.school@det.nsw.edu.au
Connect Respect Inspire

Request for support with students Health requirements at School

This request form includes 4 sections:

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

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

1. Student details -

First name:

Date of Birth: .....

Enrolled at this school ☐ Yes ☐ No Class if currently enrolled: .....

Health/medical condition:

.....

.....

Could your child experience an emergency reaction in relation to this condition?

(please tick) ☐ Yes ☐ No

Doctor's name/medical centre: .....

Doctor's address: .....

Doctor's 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	Telephone

If your child has a documented plan to support any health or medical needs from a previous school or organisation (eg preschool, occasional care, etc) please provide it to the school as an attachment to this form.

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:.....

Medication Normally Given (Including outside school hours)

Medication	**Time**	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat/Sun**
Eg. Ritalin	7:00am	½ tab	½ tab	½ tab	½ tab	½ tab	½ tab

What are you requesting the school to do? .....

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.....

Expiry date of the medication: .....

Note: if you can't provide this information now we will need to know the expiry date when the medication is given to the school.

Special storage requirements if any eg in refrigerator: .....

.....

Special instructions for administering the prescribed medication/s eg must be taken with food or with a glass of water:

.....

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 ☐

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.

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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. ***Children must not bring medication to school – must be transported by a parent/guardian.***

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.

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Note: Your child's medication should be clearly labelled with their name, and must be supplied in a Webster Pack – please see Chemist regarding this

3. Parent contact details

Name:.....

Relationship to child:.....

Address:.....

Home phone:.....Work phone: .....

Mobile phone: .....

Email: .....

Parent or carer signature: .....Date:.....

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.

Authorisation to contact medical practitioner

This form is to be completed by the parent.

My child (student's name) _____

is currently enrolled or applying for enrolment at _____ school.

I understand that the school may need to discuss the implications of my child's medical condition so that the school can support my child during school hours and during activities conducted under the auspices of the school.

I hereby give my permission for the school to contact my child's medical practitioner to obtain necessary information.

Medical practitioner information:

Name: _____

Address: _____

Phone: _____

Mobile (if known): _____

Email (if known): _____

Fax (if known): _____

I understand the information so disclosed may be discussed by the principal of the school with other members of the school staff, as is necessary, enabling staff to care for my child.

Signed: _____ Date: _____

(Parent)