WESTERN AUSTRALIAN
COLLEGE *of* AGRICULTURE
Narrogin

MEDICATION FORMS

Dear Parent/Carers

I would like to seek your assistance in maintaining our process for managing the administration of medication to students when they are in the school's care. Some prescription medication and non-prescription pain medication can be managed by college staff on request.

Non-prescription pain medications for headache, hay fever and the like are available but can only be administered by school staff if appropriate documentation has been completed by parents/carers via the blanket permission form "medication permission" that you received on enrolment.

The only exception to this is in an extreme emergency, (e.g. unexpected anaphylaxis) where staff will take all emergency treatment deemed necessary at the time.

Some medications are not desired or permitted in dorms, (eg antidepressant/dexamphetamine etc and will be held and dispensed by staff. Please seek advice from the college if unsure.

Short Term Use of Medication (up to two weeks)

For staff to administer of **short term** prescription medication such as of antibiotics, the college requires written authority from parents/carers. This authority can be provided by completing a ***College Management of Medication form***.

Note:

- The medication must be clearly labelled with the child's name.
- Documentation must be signed and dated by a parent or carer and provided to the school with the medication.

Long Term Use of Medication

If you require the school to administer medication to your child for a period of more than two weeks, you will need to complete the "Generic Health Care Management & Emergency Response Plan" form. All long term medication must be supplied to the college in a Webster Pack.

Thank you for your help.

Yours sincerely

CLARE ROSER
Principal

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COLLEGE MANAGEMENT OF MEDICATION

This form is to be used when a parent/carer requests school staff to manage medication for their child on a short term basis.

Note: Long term administration of medication should be incorporated in a health care plan on form 2 Generic Health Care Management & Emergency Response Plan

School: Year: Form:

Students Name: Date of Birth:

Family Contact Details
Address: Gender:

Telephone No: Teacher:

Section A: Medication Instructions – To be completed by parent/carer (Note: Medication must be provided by parents/carers.

	Medication 1		Medication 2	
Name of medication				
Expiry date				
Dose/frequency – (may be as per the pharmacist's label)				
Duration (dates)	From: To:		From: To:	
Route of administration				
Administration Tick appropriate box	By self (contraceptive / vitamin etc.) By self, managed by Residential Staff (prescription medication)	☐ ☐	By self (contraceptive / vitamin etc.) By self, managed by Residential Staff (prescription medication)	☐ ☐
Storage instructions Tick appropriate box(es)	Manufacturer's Pack – Dorm Room (contraceptive / vitamin etc.) Webster Pack – Duty Room (prescription medication) Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Manufacturer's Pack – Dorm Room (contraceptive / vitamin etc.) Webster Pack – Duty Room (prescription medication) Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

Will staff need to be trained to administer your child's medication? Yes ☐ No ☐ If yes, describe the type of training the staff would require:

Section B – Authority to Act

This management of medication form authorises college staff to supervise the self-administration of medication based on my/our advice and/or that of our medical practitioner. It is valid for the specified time period as noted above.

Parent/Carer: _____ Date: _____

OFFICE USE ONLY

Date received: _____

Is specific staff training required? **Yes** ☐ **No** ☐: Type of training:

Training service provider: Name of person/s to be trained:

Date of training:

When this course of medication concludes, please retain this form in the student's school file.

FORM 2 - GENERIC HEALTH CARE MANAGEMENT & EMERGENCY RESPONSE PLAN

This form is to be used when a parent/carer requests school staff to manage medication for their child on a long term basis

Name: **DOB:** **Year:** **Form:** **Teacher:**

Section A – Health Care Planning – to be completed by the parent/carer

Name of your child's health condition or need:

Daily Management Planning (if required):

Section B – Emergency Response Plan (if required) – To be completed by parent/carer and or medical practitioner

Section C – Staff Training Requirements

Is specific training for staff required to manage your child's condition or needs? (You may like to discuss with the principal or a medical practitioner).

A. For daily management? Yes ☐ No ☐ If yes, please describe:

B. In an emergency? Yes ☐ No ☐ if yes, please describe:

Section D – Medication Instructions (Note: Medication must be provided by parents/carers)

	Medication 1		Medication 2		Medication 3	
Name of medication						
Expiry date						
Dose/frequency – (may be as per the pharmacist's label)						
Duration (dates)	From: To:		From: To:		From: To:	
Route of administration						
Administration Tick appropriate box	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐
Storage instructions Tick appropriate box(es)	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

Name:	DOB:	Year:	Form:	Teacher:

Section E –Authority to Act.

I/we authorise school staff to provide health care support for my/our child in accordance with the above plan and/or the attached plan from a medical practitioner. It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

Parent/Carer: Date:	Medical Practitioner: If required (At the principal's discretion) Date:

Review Date:

OFFICE USE ONLY

Date received: / /	Date uploaded on SIS: / /
Is specific staff training required? Yes ☐ No ☐:	Type of training:

Training service provider:

Name of person/s to be trained:

Date of training:

When completed, please attach to the *Student Health Care Summary* form.