St Angela's Primary School Castle Hill
40 Harrington Avenue, Castle Hill NSW 2154
Ph: 9407 6400 Email: stangelas@parra.catholic.edu.au

Administration of Prescribed Medication

Student Name	
Student Class	
Medical Condition	☐ Asthma - Action Plan required ☐ Anaphylaxis - Action Plan required ☐ Allergies - Action Plan required ☐ Diabetes - Action Plan required ☐ Epilepsy and Seizures - Action Plan required ☐ Other: _____
Name of Medication	
Medication Dosage	
Administration of Medication	☐ Short Term Medication - From: ___ / ___ / ___ To: ___ / ___ / ___ (eg antibiotics) ☐ _____ am / pm
	☐ Long Term Stored Medication (eg Ventolin, Epipen) ☐ _____ am / pm or ☐ As required
Self Administered	☐ Yes ☐ No
Special Instructions	
Prescribing Doctor	
Doctor's Phone Number	

Conditions:

- ☐ Prescribed medication will only be given to children with written permission from parents
- ☐ Medication must be in its original container, clearly displaying the child's name, name of medication, dosage and time of administration
- ☐ Equipment for administration of medication is to be supplied by parents
- ☐ Parents must advise the school in writing of any changes to a student's medication and/or medical condition. Should your child no longer require medication please contact the school office by email stangelas@parra.catholic.edu.au
- ☐ Medication must be delivered to and collected from the office by a parent

St Angela's Staff,

Please administer my child, _____ , the medication listed above. I accept and agree to
(Full Name)

follow the conditions outlined above.

Parent Name: _____ **Parent Signature:** _____

Date:_____

Office Use		**Student Name**	
Medication Expiry Date:	____ / ____ / ____	**Action Plan Expiry Date:**	____ / ____ / ____