St Columba College
A joint Anglican and Catholic College

Medication Management Plan

FOR ALL NON-ASTHMA MEDICATION

DEAR DOCTOR,

AS PART OF OUR MEDICATION POLICY AT ST COLUMBA COLLEGE, WE REQUIRE WRITTEN AUTHORISATION FROM BOTH THE PRESCRIBING MEDICAL PRACTITIONER AND THE STUDENT'S PARENT / CAREGIVER.

COULD YOU PLEASE ASSIST IN COMPLETING THIS FORM REGARDING MEDICATION THAT IS REQUIRED DURING SCHOOL / EXCURSION / CAMPS.

THANK YOU FOR ASSISTING IN PROVIDING SAFE HEALTH CARE TO THIS STUDENT IN THE SCHOOL SETTING.

CHILD DETAILS

FAMILY NAME: _____ DATE OF BIRTH: _____ / _____ / _____

GIVEN NAME: _____ GENDER: Male ☐ Female ☐

PREFERRED NAME: _____

MEDICATION NAME: _____

DOSAGE: _____ TIME TO BE TAKEN: _____

DATE/S FROM: _____ / _____ / _____ TO _____ / _____ / _____ (all Medication Plans are updated annually)

REASONS FOR MEDICATION: _____

POSSIBLE SIDE-EFFECTS: _____

ANY OTHER COMMENTS: _____

_____

_____

DOCTOR'S NAME: _____ CONTACT NO. _____

DOCTOR'S SIGNATURE: _____ DATE: _____ / _____ / _____

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TO BE COMPLETED BY THE PARENT / GUARDIAN

DEAR PARENT/ GUARDIAN,

PLEASE READ THE INFORMATION BELOW AND SIGN THE STATEMENT BEFORE SENDING THIS FORM BACK TO THE COLLEGE:

AS PART OF THE COLLEGE MEDICATION POLICY, THE COLLEGE REQUIRES WRITTEN AUTHORISATION FROM BOTH THE PRESCRIBING MEDICAL PRACTITIONER AND THE PARENT / GUARDIAN FOR ALL PRESCRIPTION MEDICATION, INCLUDING SOME OVER-THE-COUNTER MEDICATIONS, WHICH NEED TO BE ADMINISTERED AT SCHOOL.

1. EVERY EFFORT SHALL BE MADE BY THE PARENT / GUARDIAN FOR THE STUDENT TO RECEIVE MEDICATION OUT OF SCHOOL HOURS.
2. THE FIRST OR ANY ADJUSTED DOSE OF MEDICATION SHALL BE ADMINISTERED AT HOME BY THE PARENT / GUARDIAN PRIOR TO DELIVERY OF MEDICATION TO SCHOOL.
3. MEDICATION MUST BE IN A PHARMACY CONTAINER, WHICH CLEARLY STATES THE STUDENT'S NAME, NAME OF MEDICATION, AMOUNT TO BE GIVEN, TIME TO BE GIVEN AND THE NAME OF THE PRESCRIBER. A PHARMACIST MAY PREPARE AN EXTRA CONTAINER FOR SCHOOL USE.
4. ONLY THE PARENT / GUARDIAN SHALL DELIVER OR PICK UP THE STUDENT'S MEDICATION TO OR FROM THE COLLEGE FRONT OFFICE IN THE CAMPUS THE STUDENT IS ATTENDING UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
5. ANY CHANGE IN MEDICATION ADMINISTRATION OR DOSAGE MUST HAVE A NEW PLAN SUBMITTED AND SIGNED BY A MEDICAL PRACTITIONER.
6. **ALL MEDICATION PLANS EXPIRE IN 12 MONTHS OF THE DATE WRITTEN AND THEREFORE MUST BE UPDATED YEARLY.**
7. IT IS THE RESPONSIBILITY OF THE STUDENT TO COME TO THE FIRST AID AREA AND ASK FOR THEIR MEDICATION AT THE TIME STATED BY THE MEDICAL PRACTITIONER.
8. THE COLLEGE'S AMBULANCE COVER IS FOR INJURIES THAT RESULT IN AN ACCIDENT WHILE IN THE CARE OF THE COLLEGE .THEREFORE IF AN AMBULANCE IS TO BE CALLED, IN REFERENCE TO AND ILLNESS OR PRE-EXISTING MEDICAL CONDITION, THE PARENT / CAREGIVER WILL BE RESPONSIBLE FOR THE COST.

AUTHORISATION

I, THE CAREGIVER / PARENT OF _____,

IN CLASS / HOUSE TUTOR GROUP _____,

REQUEST THAT THE STAFF AT ST COLUMBA COLLEGE ASSISTS WITH MY CHILD'S MEDICATION MANAGEMENT AS OUTLINED ON THE ATTACHED PAGE AND SIGNED BY A MEDICAL PRACTITIONER.

I HAVE READ AND AGREE TO THE ABOVE CONDITIONS AND UNDERSTAND THAT ST COLUMBA COLLEGE IS UNABLE TO ACCEPT ANY RESPONSIBILITY FOR POSSIBLE CONSEQUENCES ARISING OUT OF THE ADMINISTRATION OF THIS MEDICATION OR IN THE EVENT THAT THE MEDICATION IS NOT GIVEN, FOR ANY REASON.

PARENT / GUARDIAN SIGNATURE

PARENT / GUARDIAN NAME: _____

PARENT / GUARDIAN SIGNATURE: _____ DATE: _____ / _____ / _____