Letter of explanation to parents

Dear Parents

Please find attached the forms that need to be completed so that medication can be administered to your child during the school day.

These forms have been designed to ensure the safety of your child and to protect the school staff who do not have medical training.

Forms 1 and 2 are to be completed by you. Form 3 is to be completed by the medical practitioner prescribing the medication. Once completed please return all three forms to the school.

I am aware that this may seem a complicated process but please be assured that the school will give you every assistance in this matter.

In this instance, and as an interim measure only, we will undertake to administer medication to your child without the required documentation until ___________ (date).

Please do not hesitate to contact me if I can be of further assistance to you.

Yours sincerely,

Principal
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 __________________________ be allowed to take medication at school according to instructions from ____________________________ ____________________________

(full name of prescribing doctor)

Address of prescribing doctor: ______________________________________

Contact number: __________________________________________

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.

Signed: ____________________________ Date: ____________

parent/guardian
MEDICAL ADVICE TO SCHOOL

To be completed by prescribing doctor

Student's full name: _____________________________________________________________

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

______________________________________________________________________________
______________________________________________________________________________

2. Essential medication requiring administration during school/college hours:

Medication Details

<table>
<thead>
<tr>
<th>Condition name</th>
<th>Medication name</th>
<th>Dosage</th>
<th>Time/s of administration</th>
<th>Special instructions</th>
<th>Self-administration (yes/no)</th>
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3. Recommended restrictions on participation in school activities (e.g. sport, use of tools or machinery):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4. Recommended procedure in crisis situation

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

5. Additional comments:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Signature of prescribing doctor:___________________________________     Date:____________