KIMBOLTON SCHOOL
POLICY AND PROCEDURE FOR ADMINISTERING MEDICATION IN SCHOOL (Nag 5)

Rationale:
The school should only be requested to administer routine, non-emergency prescribed medication during the school day, when it is impossible for the parent or guardian to do so.

Purpose:
To administer medication as prescribed by a GP or specialist. (The first dose must **not** be given at school).

General Guidelines:
1. All requests must be written down, preferably on the "School to Administer Medication" form, as attached.

2. If a child is on medication that requires three doses a day it should be suggested to parents/caregivers that,
if possible, a dose could be given before school, after school and before bed.

3. The exact dose of medication must be provided by the parent / guardian to the school.

4. The medication must be kept in a safe place within the Staffroom area of the school.

5. The Principal may delegate the administering of the medication to other staff members.

Conclusion:
Medication will be administered at Kimbolton School in a safe, controlled manner.

Signed:_____

Date: _____

KIMBOLTON SCHOOL
ADMINISTRATION OF MEDICATION

I / We request that; (Child's name)_____ of

(Address)_____ be given

medication at Kimbolton School

1. I/We accept that the school does not have a trained medical officer to administer medications.

2 I/We accept responsibility for the decision to give this medication to my/our child, and acknowledge the school is in no way responsible for that decision.

3 I/We also accept that the school cannot guarantee that the medication will be given at a precise time or by that same person, although every endeavour will be made to do so.

4. I/We will notify the school of any changes to dosage or recommended time when medication is to be given.

Name of Medication:_____

Dosage and time to be given at school:_____

Date when medication is to finish:_____

Special storage requirements, ie: in fridge etc:_____

Any side effects of medication:_____

Name & Phone No of GP or specialist:_____

Signed:_____ Full Name:_____

Date:_____

RECORD OF ADMINISTRATION
To be filled in by the school

Date	Time	Dose	Signature	Date	Time	Dose	Signature

Dear Parents / Caregivers

Please fill in the form below if your child has any allergies and if medication is needed to be kept at school. One form per child please. If you need additional copies please contact the school office.

Thank you

Linda Campbell
Principal

Name of Child:_____

Asthma Yes / No
Have you completed a personalised Asthma Care Plan? Yes / No

Allergy_____

Medication to be kept at school Yes / No - (if yes what)_____

_____

_____

_____

Please note down the name of medication and expiry date.

_____

_____

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