Our Lady of Hope School

POLICY DOCUMENT

ADMINISTRATION OF MEDICATION & MANAGEMENT OF MEDICAL CONDITIONS

OUR LADY OF HOPE SCHOOL
ADMINISTRATION OF MEDICATION & MANAGEMENT OF MEDICAL CONDITIONS POLICY

1. RATIONALE/PURPOSE

1.1 Definition

Medication refers to ALL medicines/medication required to be taken for any medical condition, including prescribed and 'over the counter' medicines such as Panadol, cough syrups, and other short-term pain/symptom relief.

1.2 Aims and outcomes:

1.2.1 To inform staff and parents of their responsibilities with regard to the administration of legal drugs.

1.2.2 To ensure that only prescribed medication is administered in the correct dosage, by appropriately trained staff (Senior first Aid Certificate) to ensure students' safety and wellbeing.

1.2.3 To facilitate the ongoing education of students with specific medical conditions in an unbiased and caring manner.

1.2.4 To inform staff of the medication requirements of their students.

1.3 Waiver

Although staff will make all possible endeavours to ensure that the student has the requested medication on time, no responsibility will be taken by the school or its staff for missed medication, given the busy and unpredictable schedules of the school day.

2. SCOPE

This policy applies to all medicines/medications and all staff, students, parents, caregivers and volunteers in the Our Lady of Hope School community.

3. PROCEDURE

3.1 Medicines at school

3.1.1 It is a legal stipulation that School staff are not permitted to give medication to students unless:

- The student's medical condition is such that ongoing medication is required to enable the student to attend school AND
- Written directions stipulating the administration of the prescribed drugs are provided by the student's medical practitioner.
- The staff member must agree to administer medication (i.e. a voluntary act rather than a prescribed role). The Front Office staff normally administer all medication at Our Lady of Hope School.

3.1.2 If students bring medication to school (apart from asthma puffers, which the student may need to keep), this must be given to the school office for safekeeping, together with a Medical Plan from your medical practitioner (please see Front Office staff). *Medication must not be left in school bags, as this poses a potential risk to other students.*

3.1.3 Teaching staff are not responsible for students' medication.

3.1.4 Our Lady of Hope bears no responsibility for medication at school being out of date. It is the parent's responsibility to ensure medication has not expired.

3.1.5 School staff will not administer medication that is out of date. Where it is discovered that a student's medication is out of date, school staff will advise the students' parents.

3.1.6 No antibiotics are to be given at school. (For medication that needs to be taken 3 times per day, the second dose can be taken at home at the end of the school day and the third dose given before bed time - if you have any concerns, please consult your medical practitioner).

- Exception:- For prescribed medication 4 or more times per day, a prescription and/or Doctor's letter must be provided indicating that the student must have a dosage of prescribed medication during the school day.
- Students who are prescribed antibiotics are expected to remain away from school for at least 24hours after commencing antibiotics (unless your Doctor provides a letter stating that the student is not contagious).

3.1.7 No drops or creams will be administered, only drugs that are taken by mouth, in tablet, liquid form or inhaled.

3.1.8 'Over the counter' medication is not to be administered by school staff (e.g cough syrup – if the child is ill, then the child should not be at school, spreading infection).

3.1.9 Where possible and appropriate, first aid staff will oversight and supervise the self-administration of drugs, e.g. Asthma puffer or inhaler.

3.2 Ongoing/Long Term Medication Required to Attend School:

3.2.1 If an ongoing medical condition requiring medication is identified or when long term medication is required to enable a student to attend school, a Medication Plan and any specific care plan (see Appendices 1 to 8) are sent home to be completed by the student's medical practitioner and returned by parent/caregivers. Appendix 7 is to be completed by parent. Medication must be prescribed by a medical practitioner (Doctor) and provided in the original container bearing the child's name and within the expiry date of the product.

3.2.2 Medication provided from home is stored in a locked cupboard or refrigerator and the school will maintain a register of medication kept at school.

3.2.3 Medication administered is recorded with time, date and signed by First Aider.

3.2.4 Parents are responsible for ensuring that adequate supplies of medication are available at school. Admin staff will endeavour to contact parents when medication supply is running low.

3.2.5 Parents of students with more than one medication at school are required to provide a small soft sided thermal (lunch) bag for the medication to be kept in, this allows for easier transport on excursions and school events.

3.2.6 Children refusing to take medication are to remain in the office, parent/s to be contacted, and child is NOT to return to class until medication is taken or the parent has granted permission for the child to return to class without medication being taken. (This needs to be in agreement with Leadership if the medication relates to Behavioural needs).

3.3 Short term medication

3.3.1 Panadol and other short term medication is not given to students unless prescribed by a medical practitioner with a medication action plan from the doctor and the medication must be provided by parents/caregivers.
3.3.2 Dosage will be administered in accordance with the prescription and recorded with the time, date and signed by the First Aider.
3.3.3 Exceptions to this may apply when children attend overnight camps and where permission has been given by the parent to administer such medication.

3.4 Parent Responsibilities

3.4.1 For each new prescription, Medication must refer to the student in question, be in its original container and prescribed by a medical practitioner.
3.4.2 Students who have been sick the previous night or in the morning should be kept home and cared for to prevent further spread of illness.
3.4.3 Parents are responsible for the collection of medication at the end of each School year and returning it at the start of the following School year with an updated copy of a medical care plan (see Appendix 1-6) from the student's medical practitioner (A reminder letter and new medical forms will be sent home early in Term 4 of each school year. Medication will not be accepted at the start of the school year unless a new medication plan has been provided by the medical practitioner.
3.4.4 Parents are responsible for noting the use by dates of any medication provided to the School and to update the medication when required.
3.4.5 Parents of students requiring Continence Care at school are required to have their doctor complete the Continence Care Plan. Parents are also required to provide the school with scented nappy bags, moist towlette wipes suitable for use on sensitive skin and sufficient changes of clothing and underwear. In the event that your child needs support to change at school parents will be contacted and asked to collect soiled clothing by the end of the school day. In some cases parents will be contacted and requested to collect their child from school if there is no qualified Continence Care Staff available or in the event that the child needs to be bathed.

3.5 DUTY OF CARE

We have a duty of care to our staff and to our school community to prevent the spread of infection.

Students and Staff who are ill, sneezing, coughing, have flu like symptoms i.e. temperature, headache, nausea, have been vomiting or had diarrhoea should not return to school until they are well or have been cleared by their doctor.

Parents of students who are sent to school sick will be contacted and expected to collect them promptly to help reduce the risk of spreading infection to others.

ATTACHMENTS

Appendix 1 Asthma Care Plan
Appendix 2 Allergy care plan (including Anaphylaxis)
Appendix 3 Medication Information
(relates to individual health / personal care support)
Appendix 4 Seizure care plan
Appendix 5 Diabetes care plan
Appendix 6 General health information
(relates to general mental and/or physical health & wellbeing)
Appendix 7 Continence Care Plan
Appendix 8 Authority to Administer Medication

Appendices from Department of Education and Child Development website https://www.decd.sa.gov.au/supporting-students/health-e-safety-and-wellbeing/health-care-plans

REVIEW
Reviewed: 2018
Next review: 2021

_____ 12/12/2017

Chairperson **Date**

_____ 12/12/2017

Principal **Date**

\\carl\users$\Staff\akeane\Documents\Principal\OLOH\School Board\OLOH Board Policies\Policies under review\SBP 08 Administration of Medication Management of Medical Conditions.docx

Asthma care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Double click in the grey fields below to enter text or tick a box
Document will expand to accommodate text

Name of child/student/client: _____ (Family name, First name) Date of birth: _____

MedicAlert Number (if relevant): _____ Date for next review: _____

Description of the condition

Signs and symptoms:

- ☐ Difficulty breathing
- ☐ Wheeze
- ☐ Tightness of chest
- ☐ Cough

Frequency and severity:

- ☐ Frequently (more than 5 x per year)
- ☐ Occasionally (less than 5 x per year)
- ☐ Daily/most days
- ☐ Other: (please specify)

Triggers: *(eg exercise, chalk dust, animals, food pollens, chemicals, weather, grasses, lawn mowing)* _____

Is this student able to self manage their asthma? YES ☐ NO☐

- Remember to bring their puffer to school (clearly labelled with the original pharmacist label)
- Keep their puffer handy at all times
- Take responsibility for using their medication as directed by their doctor, e.g. before exercise
- Tell staff if they are having an asthma attack, even if they can manage it themselves. Staff need to know about the asthma attack in case it gets worse.

Curriculum considerations: *(eg physical activity, camps, excursions, kitchen, laboratory or workshop activities, interrupted attendance)* _____

Additional information attached to this care plan

- ☐ Medication plan
- ☐ Individual first aid plan (if different to standard first aid—see model over page)
- ☐ General Information about this person's condition
- ☐ Other: (please specify) _____

This plan has been developed for the following services/settings: *

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other: (please specify) _____

AUTHORISATION AND RELEASE

Health Professional: _____ Professional role: _____

Address: _____

Telephone: _____

Signature: _____ Date: _____

I have read, understood and agreed with this plan and any attachments indicated above.

I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian or adult student/client: _____ (Family name, First name)

Signature: _____ Date: _____

Asthma first aid plan

- SIT person up
- REASSURE
- STAY with person

Give blue/grey reliever puffer

- 4 puffs via spacer
- 4 breaths after each puff

ASTHMA RELIEVED

STOP TREATMENT

Observe

ASTHMA PERSISTS after 4 minutes

REPEAT RELIEVER

- 4 puffs via spacer
- 4 breaths after each puff

RELIEF

STOP TREATMENT

Cease physical activity

SEVERE BREATHING PROBLEMS
Person looks blue

NO RELIEF

CALL AMBULANCE

REPEAT RELIEVER

- 4 puffs via spacer every 4 minutes

TO CALL AMBULANCE: Dial out, then 000 or mobile 112
Say what state you are calling from, the person's condition and location

INFORM EMERGENCY CONTACTS in accordance with DECD guidelines

Department for Education and Child Development with expert advice from Australian Red Cross SA Division and Asthma SA

Allergy care plan (including Anaphylaxis)

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

☆ **NOTE: This care plan should be attached to the appropriate Australasian Society of Clinical Immunology and Allergy [ASCIA] Action Plan**
http://www.allergy.org.au/content/view/10/3/

First aid

If a child/student/client shows any of the described observable signs and symptoms, ASCIA Action Plan staff will administer first aid in accordance with Basic Emergency Life Support and including, as relevant, administration of prescribed adrenaline via an autoinjector as described on the attached ASCIA Action Plan.

If you anticipate this person will require anything other than this standard first aid response, please provide detailed written recommendations. Staff will use this plan to discuss with families how support can be provided in line with the capacities of their service.

NOTE: The child/student/client must be transported to hospital following an anaphylactic reaction and/or administration of adrenaline via an autoinjector

MEDICATION INSTRUCTIONS (if medication is **other** than the adrenaline via an autoinjector as described on the attached ASCIA Action Plan) *(please print clearly)*	
Medication name *(include generic name)*	
Form *(eg liquid, tablet, capsule, cream)*	Route *(eg oral, inhaled, topical)*
Strength	Dose
Other instructions for administration	
Start/finish date *(if appropriate)* *from* *to*	

☆ **Additional information attached to this care plan**

- ☐ Australasian Society of Clinical Immunology and Allergy [ASCIA] Action Plan
  http://www.allergy.org.au/content/view/10/3/
- ☐ General information about this person's condition
- ☐ Other (please specify) _____

*** This plan has been developed for the following services/settings:**

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)

Additional information attached to this care plan

- ☐ Medication authority
- ☐ Seizure management flow chart
- ☐ Observation/seizure log for completion by staff *(please specify how frequently this is requested)*

_____

_____

_____

_____

_____

_____

_____

- ☐ General information about this person's condition
- ☐ Other *(please specify)*

_____

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***This plan has been developed for the following services/settings:**

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Medical practitioner/epilepsy specialist _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)

Medical information

for education, childcare and community support services

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT for a child/student/client who requires individual health and personal care support. Some condition-specific forms are also available.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

Description of the condition

Observable signs and symptoms _____

Frequency and severity _____

Triggers *(if applicable)* _____

_____

Possible impact on activities *(eg physical activity, camps, excursions, kitchen, laboratory or workshop activities, interrupted attendance)*

_____

_____

_____

First Aid

If a child/student/client becomes ill or is injured, supervising staff will administer first aid and call an ambulance if necessary.

If you anticipate this child/student/client will require anything other than a standard first aid response, please provide detailed written recommendations so special arrangements can be negotiated.

Additional information attached to this care plan

- ☐ *Medication authority (if supervision of medication is recommended while in education or child/care)*
- ☐ *Individual first aid plan (if different to standard first aid—see model over page)*
- ☐ *General information about this person's condition*
- ☐ *Other (please specify)* _____

This plan has been developed for the following services/settings:

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)

Individual first aid plan

for education, child/care and community support services

CONFIDENTIAL

To be completed by the HEALTH PROFESSIONAL and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT
for a child/student/client who requires individual first aid assistance.
Standard first aid plans (for a range of conditions) can be found on http://www.decd.sa.gov.au/speced2/pages/health/chessPathways/
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

The child/student/client has a medical condition described as _____

And will require the following first aid response when these symptoms/reactions are observed.

Observable sign/reaction	First aid response

This plan has been developed for the following services/settings: *

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)* _____

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)

Seizure care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for review _____

Description of this person's usual seizure activity

Warning signs *(eg sensations)*

_____

_____

Known triggers *(eg illness, elevated temperature, flashing lights)*

_____

_____

Seizure Types

Tick all those that apply.

☐ **Tonic clonic**

- ☐ Not responsive
- ☐ Might fall down/cry out
- ☐ Body becomes stiff (tonic)
- ☐ Jerking of arms and legs occurs (clonic)
- ☐ Excessive saliva
- ☐ May be red or blue in the face
- ☐ May lose control of bladder and/or bowel
- ☐ Tongue may be bitten
- ☐ Lasts 1-3 minutes, stops suddenly or gradually
- ☐ Confusion and deep sleep (maybe hours) when in recovery phase. May have a headache.

☐ **Absence**

- ☐ Vacant stare or eyes may blink/roll up
- ☐ Lasts 5-10 seconds
- ☐ Impaired awareness (may be seated)
- ☐ Instant recovery, no memory of the event.

☐ **Simple partial**

- ☐ Staring, may blink rapidly
- ☐ Only part of the brain is involved (partial)
- ☐ Person remains conscious (simple), able to hear, may or may not be able to speak
- ☐ Jerking of parts of the body may occur
- ☐ Rapid recovery
- ☐ Person may experience sensations that aren't real:
  - sounds
  - flashing lights
  - strange taste or smell
  - 'funny tummy'
  - or may just have a headache

These are sometimes called an aura and may lead to other types of seizures.

Further information about this person's seizures

Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management.

Tonic clonic

Absence

Simple partial

Seizure Types	Further information about this person's seizures
Tick all those that apply.	Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management.
☐ **Complex partial**	**Complex partial**
☐ Only part of the brain is involved (partial) ☐ Person staring and unaware. Eyes may jerk but may talk, remain sitting or walk around ☐ Toward the end of the seizure, person may perform unusual activities, eg chewing movement, fiddling with clothes (these are called automatisms) ☐ Confused and drowsy after seizure settles, may sleep.	
☐ **Myoclonic**	**Myoclonic**
☐ Sudden simple jerk ☐ May recur many times.	

Recovery management

Signs that the seizure is starting to settle

Duration *(How long does recovery take if the seizure isn't long enough to require midazolam?)*

Person's reaction

Any other recommendations to support the person during and after a seizure

APPENDIX 5

Our Lady of Hope School

ADMINISTRATION OF MEDICATION POLICY FOR

STUDENTS WITH DIABETES

Care plans should be accessed from the DECD website listed below relating to the child's individual medical condition.

https://www.decd.sa.gov.au/supporting-students/health-e-safety-and-wellbeing/health-care-plans

Medical Practitioner is required to choose the first aid care plan that best suits the student's medical needs.

General health information

Appendix 6

for education, child/care and community support services

CONFIDENTIAL

To be completed by the TREATING HEALTH PROFESSIONAL (general practitioner, psychiatrist, psychologist) and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT for a person requiring additional care/supervision related to his or her general mental and/or physical health and well-being. Other proformas are available for more specific health care plans.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

Description of the condition

It is not necessary to provide a full medical history. Staff members only need to know information relevant to the person's attendance, learning and well-being in education, childcare or community support services.

Implications for education and care settings

Please include only information that supervising staff need to teach and care for this person, for example:

- ☐ Impact on capacity to attend and participate in routine learning activities
- ☐ Limitations on physical activity
- ☐ Need for rest/privacy
- ☐ Need for additional emotional support
- ☐ Behaviour management plan
- ☐ Considerations for camps, excursions, social outings

Please provide details _____

Description of any warning signs, triggers or circumstances and recommended responses.

Additional information

This plan has been developed for the following services/settings:

- ☐ School/education
- ☐ Childcare
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)* _____

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ _____ Signature _____ Date _____
Family name (please print) First name (please print)

Appendix 7

Continence care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the TREATING HEALTH PROFESSIONAL and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

Routine personal care/supervision for safety

Support time needed

disruption to the child/student/client's socialisation and participation.

- ☐ *Indicates when toilet is needed*
- ☐ *Needs timing*
- ☐ *Has continence aids (eg wears nappies or has catheter)*
- ☐ *May need to be changed*
- ☐ *Will always need to be changed/assisted*

Generally support will take about_____ minutes _____times each day.

Nature of support

This person is likely to need support related to:

☐ **Self-managed toileting** (*Please describe*)

- ☐ *Reminders*
- ☐ *Encouragement with fluid intake*
- ☐ *Timing*
- ☐ *Other*

_____

_____

_____

_____

_____

☐ **Assisted toileting** (*Please describe*)

- ☐ *Verbal prompts*
- ☐ *Supervision*
- ☐ *Encouragement with fluid intake*
- ☐ *Lifting onto toilet*
- ☐ *Assistance with clothing*
- ☐ *Support to weight-bear*
- ☐ *Assistance with hygiene (eg cleaning body, menstruation management)*
- ☐ *Other*
- ☐ *Assistance with washing hands*
- ☐ *Support for transfers*

_____

_____

_____

_____

_____

☐ **Catheterisation** (*Please describe*)

- ☐ Programs which allow for catheterisation at *(specify preferred times)* _____
- ☐ *Self-managed*
- ☐ *Other (eg visiting health service)*
- ☐ *Self-catheterises with supervision*

_____

_____

_____

_____

Continence supplies

Equipment/continence aids that are required _____

Location of equipment/continence aids _____

Emergency contact for supplies _____

Unplanned events

Are there any events, not covered in this plan, which could happen infrequently? If so, please give details of what could be expected and how it could be managed (*eg person is usually continent but could wet or soil occasionally; can change and clean up independently but will need reassurance*).

_____

_____

Staff will contact the parent/emergency contact if the person displays signs of possible difficulties such as sweating, discomfort, is flushed or pale, or has a headache.

Catheter management

If a person is self-managing his or her catheter and has difficulty, staff will routinely:

- *reassure the person and encourage him or her to relax and try again*
- *suggest the person wait for half an hour and come back and try again.*

If the person is still not successful, the parent/emergency contact will be informed.
A health professional can be nominated by the family as the emergency contact person in this case.
Staff will also contact the parent/emergency contact if the person displays signs of possible difficulties such as sweating, discomfort, is flushed or pale, or has a headache.

If no-one can be contacted, an ambulance may be called to transport the person to medical assistance.

Please nominate emergency contact and any different/additional steps in relation to this person's catheter management.

_____

_____

Additional information attached to this care plan

- ☐ *Medication authority*
- ☐ *Individual emergency plan (if different to standard first aid)*
- ☐ *General information about this person's condition*
- ☐ *Other (please specify)* _____

This plan has been developed for the following services/settings: *

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)

APPENDIX 8

Our Lady of Hope School

PARENT/CAREGIVER TO COMPLETE THIS FORM

AUTHORITY TO ADMINISTER PRESCRIBED MEDICATION TO STUDENT AT SCHOOL

(A SEPARATE FORM MUST BE COMPLETED BY THE PARENT/CAREGIVER FOR EACH STUDENT AND EACH MEDICATION)

NAME OF STUDENT:.....

CLASS:.....

NAME OF MEDICATION:.....

PRESCRIBING DOCTOR:.....

START DATE:..... END DATE:..... USE BY DATE ON MEDICATION:.....

(*Parents are responsible for noting use by dates and updating medication*)

QUANTITY PROVIDED TO SCHOOL (MLS/TABLETS):.....

DOSAGE:.....

WHEN TO BE TAKEN:.....

FREQUENCY:.....

POSSIBLE SIDE EFFECTS:.....

ANY OTHER RELEVANT INFORMATION:.....
.....

WAIVER: The school will make all possible endeavours to ensure that the student has the requested medication on time however no responsibility will be taken by school staff for missed medication given the busy and unpredictable schedules of the school day.

PARENT / GUARDIAN SIGNATURE:.....
DATE:.....