

FORM C: Request for Student to self-administer Medication

Parent/Legal Guardian Information

Please read this information carefully prior to completing the form.

We understand that self-management of health conditions encourages children and teens to build independence, recognise the signs/symptoms of their health condition, and administer their own medication, when required.

Self-administration of medication must be approved by the Principal prior to your child bringing any medication to school, or school based activities for self-administration. The *Request for Student to self-administer Medication* form must be completed by a parent/guardian for self-administration of medication, prior to considering approval for your child to self-administer at school or attending school-based activities. ***Controlled drugs will not be approved for self-administration.***

The Principal and/or their delegate has the right to request additional medical advice to assist in determining the suitability of the student or medication for self-administration.

All students must comply with the school code of conduct. The use or possession of any medication by students, who are not approved for self-administration, is considered a breach of the BCE Alcohol and Drug Policy.

Student Details				
Student Name:			Date of Birth:	
Address:				
	Medication 1	Medication 2 (write NA if unapplicable)	Medication 3 (write NA if unapplicable)	
Name of medicine:				
Strength:				
Dose:				
Maximum quantity to be carried at school				
Additional information	Is the medication required to be altered prior to administration? Yes ☐ No ☐ (i.e. crushing tablets, opening capsules, mixing with a liquid)			
	Does the medication need to be accessible to school staff in an emergency? Yes ☐ No ☐			
	Does the medication require specific storage to maintain integrity? Yes ☐ No ☐ (i.e. within a temperature range, refrigerated)			
Reason/s for medication:				

Student Declaration

- ☐ I am confident to carry and self-administer the medication(s) as listed above.
- ☐ I agree to keep my medication(s) in a safe place and I will not provide access to other students.
- ☐ I understand what medication I am taking and the reason for the medication.
- ☐ I can recognise early symptoms (indicators) to self-administer appropriately ('as needed' medication only).
- ☐ I agree to comply with the dosage instructions as detailed on the medicine label.
- ☐ I agree to dispose of any medication or medication administration equipment safely (if required).
- ☐ I will notify a teacher (or school staff) immediately if I need to take more than one dose of medication in a 24-hour period.

Student Signature:

Date:

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Parent/Legal Guardian Details

Parent/Legal guardian Name:

Address:

Parent/Legal Guardian Declaration

I confirm that my child: _____

(select all that apply)

- ☐ has previously carried their own medication and self-administered.
- ☐ has been instructed in the procedure of self-administration.
- ☐ can assume responsibility to carry and self-administer the medication(s) listed above safely and securely.
- ☐ knows what medication they are taking and the reasons for taking the medication.
- ☐ can recognise early symptoms (indicators) to self-administer appropriately ('as needed' medication only).

I understand that I am responsible for ensuring that:

- ☐ my child only carries the quantity of medication approved by the principal.
- ☐ the medication is in date (not expired), in the original pharmacy container with a pharmacy label that includes name, dose and administration instructions.

Parent/Legal Guardian Signature:

Date:

Principal Approval

I confirm that (name of student): _____ capable of
assuming the responsibility of carrying and self-administering the above listed medication(s).

- ☐ All associated risks have been considered when making this determination.

Where the child or young person is approved to carry and/or self-administer supervising staff are:

- ☐ aware this student is carrying their own medication.
- ☐ aware this student can self-administer their own medication.
- ☐ aware of the location of the medication (if required in an emergency).

Principal Signature:

Date:

Principal Name:

Decision/Risk notes