PETER MOYES ANGLICAN COMMUNITY SCHOOL

ACTION PLAN FOR

MEDICATION FROM PRESCRIBING DOCTOR

REQUEST FORM 2020

Note: A new request form is required
* If the dose or medication type is altered and/or
* If the regimen is re-started following the expiration of this order and/or
* At the beginning of each NEW calendar year;

Student Name: _____ Date of Birth _____

Gender (M) (F)

Year Group _____

Plan prepared by Doctor

Doctor's Stamp

I have prescribed the drug/medicine: _____

to treat the condition of: _____

(name of medical condition)

The drug/medicine dosage and frequency needing to be administered is: _____ _____

(dose) (frequency/time)

Are special arrangements necessary to administer the drug/medicine or monitor student after drug administration? ☐ Yes ☐ No

If so, provide details.

_____

_____

Signature of Doctor _____ **Date** _____

Signature of Parent/Guardian/Carer: _____ **Date** _____

Signature of Associate Principal/ Deputy Associate Principal or Principal: _____ **Date** _____

****These instructions are requested from the prescribing doctor to enable the School to maintain its 'duty of care' administering prescribed drugs/medicines to Students whose condition would otherwise preclude attendance at School or School Camps.****