HEBRON CHRISTIAN ACADEMY

REQUEST FROM PARENTS: ADMINISTERING OF MEDICATION BY THE SCHOOL

The school can refuse to administer medication to your child if the form below is not completed by both you and your medical doctor. The school has the right to refuse to administer medication should all the conditions as described in the WCED guidelines not be met.

A) DETAILS OF LEARNER:

Surname: …… First name(s): …….....

Learner's residential address: …….....

Date of birth: …….. Male ☐ Female ☐

Grade: …… Class teacher: …….....

Condition or illness: …….....

A) MEDICATION TO BE ADMINISTERED:

Brand name of medication, as described on original container

…….....

Has a copy of the original script/prescription been provided to the school? Yes / No

Date of script: ……. Date dispensed: …….....

For how long will your child be taking this medication (*exact dates*)? …… to ……..……

B) FULL DIRECTIONS FOR USE (*as per script/medical practitioner*)

Dosage:……(Quantity)……(Times).....

Method of administering:

…….....

Frequency and time of administering (a.m./p.m./lunch time/etc.):

…….....

Special precautions/instructions (e.g. storage):

…….....

Possible side-effects:

…….....

Can the medication to be self-administered? Yes ☐ No ☐

Action to be taken in an emergency:

…….....

Known and diagnosed Allergies:

…….....

Name of prescribing medical practitioner:

…….....

Contact details of medical practitioner:

…….....

Name of dispensing pharmacist:

…….....

Contact details of pharmacist:

…….....

C) CONTACT DETAILS (*in case of emergency)*

Name of parent/s: …….....

Contact telephone number/s: …….....

Relationship to learner: …….....

D) DECLARATION BY PARENT:

I, ……do hereby request HEBRON CHRISTIAN ACADEMY (*Name of school*) to administer the above-mentioned medication(s) to my child …… (Name) as detailed above

I have read the recommended guidelines for the administering of medications by schools and agree to the requirements of this guideline document. I understand that the school has the right to refuse to administer the medication if these requirements are not met. I understand that this request is valid for six (6) months only and will need to be reviewed and /or renewed annually.

In making this request I confirm the following conditions;

- Medication must be supplied in the original container. I will request the pharmacist to supply medication in two fully labelled containers, one for home use and one for school use.
- Only medication authorized by a medical practitioner may be administered by school personnel.
- It is my responsibility to notify the school when there is a change in medication.
- It is my responsibility to provide all supplies, medication and/or equipment necessary for the administering of any medication(s), and to collect from the school any medication not used during the specified period.

I furthermore authorize the principal or designated school personnel member to contact the medical practitioner or pharmacist listed above in the event of illness or adverse reactions.

Signature: …….. Date: ……..