ERSKINE PARK HIGH SCHOOL

Medication Instructions/Agreement

Please tick appropriate box

☐ Non Prescribed Medication

☐ Prescribed Medication

Prescribing Doctors name _____

Prescribing Doctors Phone Number _____

This letter is to advise that (Student) _____ of

(Year)_____requires administration of medication

From (date)_____ to (date) _____.

(Student)_____is required to take (Dosage) _____ of

(Medication)_____ at

(Time)_____.

Special storage instructions _____

_____

In case of asthma puffer or Epipen, your request for _____ (student's name) to self-administer prescribed medication is supported. In the case of an Epipen, the school must also be provided with a prescribed Epipen, pharmacy labelled with your child's name to store for emergencies. The school will continue to work with you to support your child in managing the administration of this medication).

The Medication and associated equipment must be provided to the school in a pharmacy labelled container with students name and dosage requirements noted.

The school will make every endeavour to provide the medication at the times requested although some variations may be unavoidable on occasions.

If there are any changes in your child's health care needs or your contact details, please inform the school as soon as possible. Please contact the school if at any time you have any concerns or questions about these arrangements for support.

_____Parent Signature _____Date