

# SAINT PETER CHANEL CATHOLIC SCHOOL

5 VARDON ROAD, TE RAPA HAMILTON 3200 TELEPHONE 07-849 3734 FACSIMILE 07-849 4183 EMAIL admin@spc.ac.nz www.spc.ac.nz

### **Administration of Medication at School Policy**

#### **Rationale**

The dispensing of medication needs to be under strict controlled conditions for the safety of children and staff.

#### Purposes

- To protect children requiring medicine and adults administering medication at school.
- To ensure safe storage and administration of medicine at school.
- To ensure parental consent and correct instructions for administration of Medicine at school.

#### **Guidelines**

- 1. Medicines must be in their original containers, labelled with the child's name and dose to be given.
- 2. Needs for long term medication will be discussed fully with the Principal, responsible staff member and parent/caregiver of the child.
- 3. Medicine will be stored in a secure place and be dispensed by a designated staff member.
- 4. Short courses of Medications of which are required to be taken 3 times a day will not be administered at school. Parents will be advised to give doses before school, after school and in the evening. This eliminates the need to have medicines at school.
- 5. Medication will not be administered without consent except in emergency situations e.g. Asthma attacks that require a broncho-dilator such as Ventolin, or bee stings where immediate medication is required.
- 6. All medication administered will be recorded in the First Aid Treatment Book.

If a parent or designated person administers any medication during school hours the classroom teacher must be informed. The person who administers the medication must record and sign the First Aid Treatment Book located in the staffroom.



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### Consent for Medicine to be given at school

Child's Name:	Date:	
Medicine (name)		
Dose (amount)		
Times medicine to be given		
Medicine to be given at the above times for _		days
Doctor's Name:	Phone:	
Teacher's Name:		
Parent/Caregivers name (printed)		
Parent/Caregiver's signature		

## **Medication Given**

Date	Time	Dose	Signature