



Request for support at school of a student's health condition

Information

Name of child: DOB:

☐ Enrolled or

☐ Seeking enrolment (tick)

Class (if enrolled): School:

Parent contact

Parent information (1)

Name:

Relationship to child:

Address:

Home phone: Work phone:

Mobile phone:

Parent information (2)

Name:

Relationship to child:

Home phone: Work phone:

Mobile phone:

Medical practitioner contact

Name:

Address:

Phone:

Health/medical condition (three lines)

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Could your child experience an emergency reaction in relation to this condition?

Yes ☐

No ☐



Request for other support

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Parent or carer signature:..... Date:

Privacy notice
The information requested on the form is essential for assisting the school to plan for the support of your child's health needs. It will be used by the NSW Department of Education and Training for the development of arrangements with you to support your child's health needs. Provision of this information is voluntary. If you do not provide all or any of this information, the school's capacity to support your child's health needs could be impaired. This information will be stored securely. You may correct any personal information provided at any time by contacting the Principal.



Request for administering prescribed medication to the student

(Note: if your child is to take more than one prescribed medication, please attach a separate request for each medication.)

Name of prescribed medication:

Prescribed for (name of medical condition):.....

Prescribed dosage:

What are you requesting the school to do?

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Special storage requirements if any eg in refrigerator:.....

Special instructions for administering the prescribed medication/s eg must
be taken with food or with a glass of water:

Through information you have obtained from your doctor or acquired
yourself, are you aware of any likely side effects from the prescribed
medication?

Yes ☐ No ☐ If Yes, Please provide more information:

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If your child administers his or her own medication at home, do you request
that he or she self administers this medication at school?

Yes ☐ No ☐

*(Note: The Principal needs to approve a decision for a student to self
administer).*

If your child self administers the medication at home, what level of support
do you provide? (Please describe):.....

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Name of person who will carry the medication to school:.....

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