ONKAPARINGA SWIMMING CLUB
MEDICATION PLAN

CONFIDENTIAL

To be completed by the PARENT/GUARDIAN for a child who requires supervision of medication while on camp. This information is confidential and will be available to Onkaparinga supervising coaches, camp staff and emergency medical personnel if required.

Please note that Coaches:

- *accept only medication which has been ordered by a doctor and is provided in the original, fully labelled pharmacy container*
- *are instructed to seek emergency medical assistance if concerned about a swimmer's behaviour following medication.*

Name ____ Date of birth________________

Family name (please print) First name (please print)

Medic Alert number (if relevant)___________________________________ Review date________________

MEDICATION INSTRUCTIONS ***(Please print clearly)***	**TIME** ***(Please indicate times relevant to schooling)***
Medication name and form *(eg liquid, capsule, ointment)*	☐ Early morning
Dose	☐ Mid-morning ☐ Middle of the day
Route *(eg oral or inhaled)*	☐ Mid-afternoon ☐ Evening
Any other instruction	☐ Other (please specify)

Please note:

- *Swimmer will generally be supervised when they take their oral/puffer medication and or other medications*
- *Wherever possible, safe self-management of a puffer is encouraged*

Please advise if condition creates any difficulties with self-management; for example, difficulty remembering to take medication at a specified time or difficulties co-ordinating equipment (eg puffer and spacer) please make sure we can ask if there medication has been taken and record or make note of time etc..

AUTHORISATION AND RELEASE

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to coaches and any emergency medical personnel.

Parent/Guardian________________________________ Signature____________________ Date____________

Family Name (please print) First Name (please print)