



***Notes to Parent / Guardians***

***Note 1:*** *This establishment will only give your child medicine when you have completed and signed this form and where there is a school policy that staff can administer medicine.*

***Note 2:*** *All medicines must be in the original container as dispensed by the pharmacy, with the young person’s name, its contents, the dosage and the prescribing doctor’s name.*

***Note 3:*** *The information is requested, in confidence, to ensure that the establishment is fully aware of the medical needs of your child. The school will endeavour to administer* ***prescribed medication only****, and* ***only when parental consent has been given****. Staff are not obliged to administer medicines, but will make all efforts to do so in partnership with parents and carers. In the event that the school is unable to administer medicine, parents are requested to make alternative arrangements themselves.*

***Note 4:*** *The school will endeavour to administer one dose of prescribed medication only during normal school hours, unless there is exceptional medical need for more than one dose. Parents and Carers are reminded that, in the event of multiple doses needing to be administered, prior agreement must be sought from the school office.*

**Prescribed Medication**

|  |  |
| --- | --- |
| Date |  |
| Child’s name |  |
| Class Name |  |
| Medicine to be administered - please note that we will only administer the dosage as shown on the pharmacists label. This is given just before midday unless there is a specific medical reason and this is agreed with the school office.  |  |
| Reason for medication |  |
| Type of medicine |  |
| Does this need to be kept in the fridge | YES/NO |
| Time limit – how long your child needs to be taking the medication | \_\_\_\_\_\_\_\_\_day/s \_\_\_\_\_\_\_\_\_week/s |

|  |  |
| --- | --- |
| Daytime phone number of parent or adult contact |  |
| Alternative contact in the event of an emergency |  |

I confirm that the medicine detailed overleaf has been prescribed by a doctor, and that I give my permission for the member of staff to administer the medicine to my son/daughter.

I also agree that I am responsible for collecting the medication at the end of the school day and the disposal of any used containers. .

The above information is, to the best of my knowledge, accurate at the time of writing.

Parent’s Signature Date Date

(Parent/Guardian/Person with parental responsibility)

……………………………………………………………………………………………………………..

**FOR SCHOOL USE ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Time | Dosage | Given By | Any reaction? |
|  |  |  |  | Yes / No |
|  |  |  |  | Yes / No |
|  |  |  |  | Yes / No |
|  |  |  |  | Yes / No |
|  |  |  |  | Yes / No |