

 **ADMINISTRATION OF MEDICINES IN SCHOOL**

Name of Pupil: Year:

Address:

Emergency Contact Number

Medical Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Name of Medication**  | **Dose and Method** | **Times** | **Time of Last Dose** |
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| **Are there any side effects that the school should know about?** |

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| **Procedures to take in an emergency:** |

**Please Note: Only medicines prescribed by a doctor will be administered to your child at school.**

This form should be completed by the parent, guardian or person with parental responsibility for the child and delivered with the medication to the school office.

**The medicine should be in date and clearly labelled with:**

* **Its contents**
* **The owners name**
* **Dosage and frequency**
* **Name of prescribing doctor**

It is your responsibility to ensure that the school is kept informed in writing about any changes to your child’s medicines, including how much they take and when.

This information overleaf is requested, in confidence, to ensure that the school is fully aware of the medical needs of your child.

**Parental Consent**

I confirm that a doctor has prescribed the above medication.

I give permission for the nominee to administer the medication to my child.

I accept that this is a service that the school is not obliged to undertake.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent or person with parental responsibility)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Date  | Medicine | Time | Signature  | Print Name  |
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**For School to complete**