Parental Agreement to Administer Prescription or Non-prescription Medicine

Shaldon Primary School

Notes to Parent / Guardians

Note 1: This school will only give your pupil medicine after you have completed and signed this form.

Note 2: All medicines must be in the original container as dispensed by the pharmacy, with the pupil's name, its contents, the dosage and the prescribing doctor's name as appropriate.

Note 3: The information is requested, in confidence, to ensure that the School is fully aware of the medical needs of your child.

Date	
Pupil's name	
Date of birth	
Class/Year Group	
Reason for medication	
Name / type of medicine (as described on the container)	
Expiry date of medication	
How much to give (i.e. dose to be given)	
Time(s) for medication to be given	
Special precautions/ other instructions – eg when to be taken – before / after food	

Are there any side effects that the academy needs to know about?	
Procedures to take in an emergency	
I understand that I must deliver the medicine personally to the schools reception staff	
Time limit – please specify how long your pupil needs to be taking the medication	_____day/s_____week/s
I give permission for my son/daughter to be administered the emergency inhaler held by the school in the event of an emergency	Yes / No/ Not applicable
I give permission for my son/daughter to carry their own asthma inhalers	Yes / No / Not applicable
I give permission for my son/daughter to carry their own asthma inhaler and manage its use	Yes / No / Not applicable

Details of Person Completing the Form:

Name of parent/guardian	
Relationship to pupil	
Daytime telephone number	
Alternative contact details in the event of an emergency	
Name and phone number of GP	
Agreed review date to be initiated by [named member of staff]	

I confirm that the medicine detailed overleaf has been prescribed by a doctor, and that I give my permission for the Headteacher (or a nominee) to administer the medicine to my son/daughter during the time he/she is at the School.

OR

I confirm that the non-prescribed medicine detailed overleaf is suitable for my child and I give permission for the Headteacher (or a nominee) to administer the medicine to my son/daughter during the time he/she is at the School.

I will inform the School immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. I also agree that I am responsible for collecting any unused or out of date supplies and that I will dispose of the supplies.

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

Parent's Signature

_____

Date _____

(Parent/Guardian/person with parental responsibility)

Administered Medicines

Date Administered	Time	Member of staff signature