ALL SAINTS CE FIRST SCHOOL

REQUEST FOR A SCHOOL TO ADMINISTER ***PRESCRIBED*** MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Headteacher has agreed that school staff can administer the medicine

Details of Pupil

Full Name: _____ **DOB:** ____/____/_____

Condition/Illness: _____

Name of Medication: _____

Parents must ensure that in date, properly labelled, medication is supplied.

Type of Medication (e.g. **Tablets/Medicine/Spray/Drops**) **Date Dispensed:** _____

Expiry Date: _____

Any Special Storage Instructions (eg Fridge) _____

Full Directions for use:

Dosage/Timing/Method of Administration: _____

_____

NB *Dosage can only be changed on a Doctor's instructions*

Start Date: _____ **End Date:** _____

Special precautions: _____

Are there any possible side effects that the School needs to know about?: _____

_____

Self-Administration: Yes/No (delete as appropriate)

Procedures to take in an Emergency: _____

Emergency Contact Details:

Name: _____ **Relationship to Pupil:** _____

Telephone No: _____

I understand that I must deliver the medicine personally to the School Office and accept that this is a service, which the school is not obliged to undertake. I understand that I must notify the school of any changes in writing.

Signature: _____ **Date:** _____

Agreement of Headteacher

I agree that _____ (name of child) will receive _____

_____ (Quantity and name of medicine)

every day at _____ (time(s) medicine to be administered.

This child will be given/supervised whilst he/she takes their medication by _____

(Name of staff member)

This arrangement will continue until _____

Signed: _____ **Date:** _____

(**The Headteacher/Authorised Member of staff)**

The original should be retained in the school files and a copy given to the class teacher for the classroom medication/first aid file.