Horton, St. Michael's CE (VC) First School

Parental Request for the Administration of Prescription Medicines in School

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING PRESCRIPTION DRUGS TO BE ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF OR WHERE A CHILD IS BRINGING MEDICINE INTO SCHOOL WHICH THEY WILL SELF ADMINISTER.

If you need help to complete this form, please contact the school. Please complete in BLOCK letters.

Name of child: _____ Date of Birth: _____

Doctor's Name: _____

PRESCRIBED MEDICINES

The Doctor has prescribed (as follows) for my child:

Name of Drug or Medicine to be given and any special storage instructions	**When? e.g., Lunchtime? After food? When wheezy? Before exercise?**	**How much e.g., half a Teaspoon? 1 tablet? 2 drops?**	**Route e.g., by mouth or in each ear**

(Child's Name): _____

Can administer his/her own medication*/requires supervision to administer his/her own medicine*/requires assistance in administering his/her own medicine*

_____

_____

I request that the treatment be given in accordance with the above information by a named member of the school staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.

I undertake to supply the school with the drugs and medicines in the original duplicate labelled containers, provided by the Dispensing Chemist.

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent and that the school staff may, therefore, need to arrange any medical aid considered necessary in an emergency, but will be told of any such action as soon as possible.

I can be contacted at the following address/telephone during school hours.

Name: _____ Signed: _____

Contact Address: _____ Date: _____

_____

_____

_____

Contact Tel No: _____

* Delete that which does not apply

MEDICATION SIGN IN/OUT

Date	Signed In	PRINTED	Signed Out	PRINTED

THIS FORM SHOULD BE SECURELY FILED AWAY WITH THE PUPILS NOTES IN THE SCHOOL OFFICE WHEN THE MEDICATION IS COMPLETED OR CHANGED

Horton, St. Michael's CE (VC) First School

School Medicine Record

(To be kept in the classroom)

Child's Name:	
Class/Tutor Group:	
Name of Medicine:	
How much to give (i.e. dose)	
When to be given	
Any other instructions (include details of inhalers, if any)	
Telephone numbers of parent or adult contact	
Parent's signature obtained via Parental consent form	

IF MORE THAN ONE MEDICINE IS TO BE GIVEN, A SEPARATE FORM SHOULD BE COMPLETED.

ADDITIONAL COMMENTS: