**Parental request for medicine to be taken at school**

School staff should not give your child medicine unless you complete and sign this form.

The school has a policy that staff can administer certain medicines.

|  |  |
| --- | --- |
| Child’s Name: | DOB: |
| Medical Condition/illness: | Tutor Group: |
| Name/type of medicine(as described on the container/package? | NB: Medicines must be in the original packaging |
| Expiry Date? |  |
| Dosage and Method? |  |
| Times of day, medicine is to be taken? |  |
| Date and time of the most recent dose taken, if applicable. |  |
| Special instructions/precautions |  |
| Are there any side effects that the school need to be aware of? |  |
| Procedures to take in an emergency? |  |

The above information is, to the best of my knowledge, accurate at the time of writing and give consent to school staff administering medicine in accordance with the school policy and the prescriber’s instructions.

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 no longer required.

I understand that, where medicine is not self-administered, it will be given by non-medically qualified staff.

I agree to not hold staff responsible for loss, damage or injury when undertaking agreed administration/supervision of medication, unless resulting from their negligence.

I will abide by the school’s policy and procedure for the delivery and return of medication.

I will ensure an adequate supply of in date medication.

|  |
| --- |
| Name of Parent: |
| Signature of Parent: |
| Date: |
| Relationship to Child: |

School Consent:

* The school agree to administer the above as requested.
* Staff administering medication or supervising the administration of medication have received any necessary training
* Staff are insured to undertake the above

|  |
| --- |
| Name of Headteacher or designated person: |
| Signature: |
| Date: |