**The Carey Federation**

**Administration of medicines in school**

**Parental agreement for school to administer medicine.**

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

|  |  |  |  |
| --- | --- | --- | --- |
| Name of school |  | Date |  |
| Child’s name |  | Class |  |
| Name and strength of medicine |  | Expiry date  |  |
| How should the medicine be stored (i.e. in or out of the fridge) |  | How much to give (i.e. dose to be given) |  |
| When to be given |  | Reason for medication |  |
| Number of tablets/quantity to be given to school |  | Time limit – please specify how long your child needs to be taking the medication. | Day/s: Week/s: Other: |

|  |  |  |  |
| --- | --- | --- | --- |
| Daytime phone number of parent or adult contact |  | Name and phone number of GP |  |
| Agreed review date to be initiated by Mrs Alford. |  | **Note: Medicines must be in the original container.** |

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

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

Parent’s signature. (Parent/Guardian/Person with parental responsibility): Date:

I confirm that the medicine detailed above, **has NOT been prescribed**, however I give permission for the Headteacher (or his/her nominee) to administer the medicine to my son/daughter during the time he/she is at 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.

Parent’s signature. (Parent/Guardian/Person with parental responsibility): Date:

I give permission for my son/daughter to carry their asthma inhaler with them whilst at school and to manage its use.

Parent’s signature. (Parent/Guardian/Person with parental responsibility): Date:

I agree that the school will administer the above medication as described.

Headteacher’s signature: Date:

**NOTES OF GUIDANCE**

* The Headteacher (or his/her nominee) will only administer medicines prescribed by a doctor.
* This form should be completed by the parent or guardian of the pupil and be delivered personally, together with the medicine to the Headteacher or his/her nominee.
* The medicine should be in date and clearly labelled with: **Its contents;** **The owners name; Dosage, and The prescribing doctor’s name.**
* The information given above is requested, in confidence to ensure that the Headteacher is fully aware of the medical needs of your child.

While no staff member can be compelled to give medical treatment to a pupil, it is hoped that the support given through parental consent, the support of the County Council through these guidelines, and the help of the School Medical Service will encourage them to see this as part of the pastoral role. Where such arrangements fail, it is the parent’s responsibility to make appropriate alternative arrangements.