PARENTAL AGREEMENT TO ADMINISTER PRESCRIPTION MEDICINE

South Tawton Primary School Notes to Parent / Guardians

Note 1: This school will only give your student 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 student's name, its contents, the dosage and the prescribing doctor's name

Note 3: The information is requested, in confidence, to ensure that the school is fully aware of the medical needs of your student. Prescribed Medication

Prescribed Medication

Date	
Student's name	
Date of birth	
Class	
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 (e.g. to be taken with/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 class teacher or office staff	
Number of tablets/quantity to be given	
Time limit – please specify how long your student 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
I give permission for my teenage son/daughter to carry their adrenaline auto injector for	Yes / No/ Not applicable

anaphylaxis (epi pen)	
I give permission for my son/daughter to carry and administer their own medication in accordance with the agreement of the school staff	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 her nominee) to administer the medicine to my son/daughter during the time he/she is at South Tawton Primary 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)

Log of medicines Administered

Date	Time	Dose Given	Staff name	Notes