ADMINISTERING MEDICINE IN SCHOOL

Appendix 2: School Parental Agreement

THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN

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 Sacred Heart Primary School

Name of Child: _____

Date of Birth: _____

Class: _____

Medical condition/illness: _____

Medicine _____

Name/Type of Medicine (as described on the container): _____

Date dispensed: _____

Expiry date: _____

Agreed review date to be initiated by *[name of member of staff]:* _____

Dosage and method: _____

Timing: _____

Special Precautions:
Are there any side effects that the school should know about? _____

_____

Self Administration: Yes/No (delete as appropriate)

Procedures to take in an Emergency: _____

Contact Details Name: _____

Daytime Telephone No: _____

Relationship to Child: Address: _____

_____

I understand that I must deliver the medicine personally to the school and accept that this is a service that the school is not obliged to undertake.

I understand that I must notify the school of any changes in writing

Date: _____

Signature(s) _____

_____

Relationship to child: _____

Appendix 4: Welfare Officer Agreement

Confirmation of the Welfare Officer's agreement to administer medicine

It is agreed that _____

will receive_____every day at _____.

_____will be given/supervised whilst he/she takes their medication by_____.

This arrangement will continue until [either end date of course of medicine or until instructed by parents] _____.

Date: _____

Signed: _____

Mrs J Butler

Appendix 5: Record of medicine administered to an individual child

Name of Child ______________________________

Date medicine provided by parent ______________________________

Class ______________________________

Quantity received ______________________________

Name and strength of medicine ______________________________

Expiry date ______________________________

Quantity returned ______________________________

Dose and frequency of medicine

Date					
Time Given					
Dose Given					
Staff Name					

Date					
Time Given					
Dose Given					
Staff Name					

Date					
Time Given					
Dose Given					
Staff Name					

Date					
Time Given					
Dose Given					
Staff Name					

Date					
Time Given					
Dose Given					
Staff Name					

Appendix 6: Request for a child to carry his/her own medicines

THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN

Child's Name: _____ _____

Class: _____

Address: _____

_____

Name of Medicine: _____

Procedures to be taken in an emergency: _____

Contact Information

Name: _____

Daytime Phone No: _____

Relationship to child: _____

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

Signed:	Date:

If more than one medicine is to be given a separate form should be completed for each one.