**PARENTAL AGREEMENT TO ADMINISTER PRESCRIPTION MEDICINE**

Diptford Parochial CofE Primary School

**Notes to Parent / Guardians**

Note 1: This school will only give your student medicine after you havecompleted 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**

|  |  |
| --- | --- |
| Date |  |
| Student’s name |  |
| Date of birth |  |
| Class/Year |  |
| 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 school needs to know about? |  |
| Procedures to take in an emergency |  |
| I understand that I must deliver the medicine personally to the School Administrator |  |
| 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 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 |

**Details of Person Completing the Form:**

|  |  |
| --- | --- |
| Name of parent/guardian |  |
| Relationship to student |  |
| 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 Head of School (or his/her nominee) to administer the medicine to my son/daughter during the time he/she is at Diptford 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 I also agree that I am responsible for collecting any unused or out of date supplies and that I will dispose of the supplies.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)