**WALSH C. OF E. JUNIOR SCHOOL**

**Parental Agreement for School to Administer Medication**

The school will not give your child medicine unless you complete and sign this form.

|  |  |
| --- | --- |
| Name of pupil: |  |
| Date of birth: |  / / |
| Class name: |  |
| Medical condition or illness medication required for: |  |

**Please note:**

* **Medicines must be in the original container as dispensed by the pharmacy.**
* **Ibuprofen will only be administered if prescribed by your child’s GP**

|  |  |
| --- | --- |
| Has this medication been prescribed by your child’s GP? |  Yes / No |
| Name/type of medicine (as described on the container) |  |
| Date dispensed: |  / / |
| Expiry date: |  / / |
| Dosage and method: |  |
| Timing: |  |
| Special instructions (i.e. storage, to be taken before food etc): |  |
| Are there any side effects that the school needs to know about? |  |
| Procedures to take in an emergency |  |

**Contact Details**

|  |  |
| --- | --- |
| Name: |  |
| Daytime telephone number: |  |
| Relationship to student: |   |
| **I understand that an adult must personally deliver and collect the medicine from to/from the school office** | ❑ (please tick) |

**Please tick the appropriate box:**

* My child will be responsible for the self-administration of medicines as directed above.
* I agree to members of staff administering medicines/providing treatment to my child as directed above.

**Other prescribed medicines my child takes at home: …………………………………………………………………………………….**

**.…….………………………………………………………………………………………………………………………………………………………………**

**PLEASE READ AND SIGN FORM OVERLEAF:**

* Non-prescribed medication - I confirm my child has taken this medication before and has not experienced any side effects.
* I agree to update information about my child’s medical needs held by the school.
* I will ensure I will periodically check that the medicine held by the school does not exceed its expiry date.
* I will collect the medication when the course is complete and dispose of it safely.

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. I 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.

Parent/Carer’s signature: …………………………………………………………………………………………….. Date: …………………………

Print name: …………………………………………………………………………………………………………………..

**--------------------------------------------------------------------------------------------------------------------------------------------------**

**Pupil Medication Record**

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Date** | **Time** | **Medicine Given** | **Dose** | **Signature** |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| 5. |  |  |  |  |  |
| 6. |  |  |  |  |  |
| 7. |  |  |  |  |  |
| 8. |  |  |  |  |  |
| 9. |  |  |  |  |  |
| 10. |  |  |  |  |  |
| 11. |  |  |  |  |  |
| 12. |  |  |  |  |  |
| 13. |  |  |  |  |  |