**Administering Prescribed Medicine Form**

**Parental consent for the Administering of Prescribed Medicine or Treatment to Children and Record of Administration and Prescribed Medicine to Children**

**The school will not give your child the prescribed medicine unless you complete and sign this part of the form.** If more than one medicine is to be administered, a separate form should be completed for each one

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| --- | --- | --- | --- |
| **Child’s name** | ………………………………..………………………………………………………………… | | |
| **Date of Birth** | ………………………………..…………………… | **Year** | ………………..………… |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name and strength of medicine** | …………………………………………………………………………... | | |
| **Date of dispensing** | …………….………….….. | **Expiry date** | ……………………… |
| **Method of administration (eg oral)** | …………………………………………………………………………... | | |
| **Dosage to be administered (how much)** | …………………………………………………….…………………….. | | |
| **When to be given/frequency of administration** | ………………………………………………………………….……….. | | |
| **Duration of treatment** | ………………………………………………………………….……….. | | |
| **Storage instructions** | …………………………………………………………………………… | | |
| **Are there any side effects the  school need to know?** | …………………………………………………………………………… | | |

Please include the Patient Information Leaflet (if possible). Medicines must be in the original container, as dispensed by the pharmacy. The above directions must be consistent with the instructions of the prescriber, as printed on the original container. Delivery of medicine should be made to the school by the parent or by another adult at the request of the parent.

|  |  |
| --- | --- |
| **Contact name of parent/carer** | ………………………………………………………………….……….. |
| **Contact number of parent/carer** | ………………………………………………………………….……….. |
| **GP name and contact number** | ………………………………………………………………….……….. |

**The above information is, to the best of my/our knowledge, accurate at the time of writing and I/we give consent to school staff administering medicine in accordance with the school policy. I/we agree that the treatment may be administered by persons without medical qualifications. I/We 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/We acknowledge that the school cannot guarantee compliance with the treatment directions should unforeseen circumstances arise and that the school will not be liable for any shortcomings in treatment.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/Carer’s name** | ……………………………………………………………………………….. | | |
| **Parent/Carer’s signature** | …………….…………………….….. | **Date** | ……………..…………… |

**Record of Administration of Prescribed Medicine to a child**

(to be completed by the staff member administering the medication).

It is the responsibility of the staff member administering the prescribed medication to ensure all details completed by the parent overleaf are consistent with the instructions of the prescriber, as printed on the original container, prior to administration of the medicine.

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| --- | --- | --- | --- | --- | --- |
| **Date** |  |  |  |  |  |
| **Time Administered** |  |  |  |  |  |
| **Dose Administered** |  |  |  |  |  |
| **Administered by** |  |  |  |  |  |
| **Staff initials** |  |  |  |  |  |
| **Administration witnessed by (initials)** |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** |  |  |  |  |  |
| **Time Administered** |  |  |  |  |  |
| **Dose Administered** |  |  |  |  |  |
| **Administered by** |  |  |  |  |  |
| **Staff initials** |  |  |  |  |  |
| **Administration witnessed by (initials)** |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/Carer’s signature** | …………….…………………….….. | **Date** | ……………..…………… |

This form should remain at school however a copy may be supplied to the parent/guardian at their request.