# Parental request for medicine to be taken at Kirkby Malzeard School

School staff will not give your child medicine unless you complete and sign this form. The school has a policy that the staff can administer prescribed medicines only and all medicine to be supplied in box with full instructions and bottles labelled.

|  |  |  |
| --- | --- | --- |
| **Child’s name:** |  | **DOB:** |
| **Medical condition/illness:** |  | **Class/Yr.:** |
| **Name/type of medicine**  ***(as described on the container and label visable)*** | **NB: Medicines must be in the original container as dispensed by the pharmacy** | |
| **Expiry date** |  | |
| **Dosage and method** |  | |
| **Storage instructions** |  | |
| **Times of day medicine is to be administered** |  | |
| **Date and time the most recent dose was given** ( school should not give the first dose of a medicine ) |  | |
| **Special precautions / instructions** |  | |
| **Are there any side effects that the school needs to know about?** |  | |
| **Procedures to take in an emergency** |  | |

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 in accordance with the school policy and the prescriber’s instructions.

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 understand that, where medicine is not self- administered, it will be given by non-medically qualified staff.

I agree not to hold staff responsible for loss, damage or injury when undertaking agreed administration/supervision of medication unless resulting from their negligence

I will abide by the school’s policy and procedure for the delivery and return of medication

I will ensure adequate supply of in date medication

Name of Parent / Carer.................................................................................................

Signature of Parent / Carer………………………………………… Date………………

Relationship to Child………………………………………………………………………..

**School Consent:**

* The school agree to administer the above as requested
* Staff administering medication or supervising the administration of medication have received any necessary training
* Staff are insured to undertake the above

Name of Headteacher/designated person…………………………………………..

Signature ………………………………………………………Date………………….

NB: If more than 1 medication is to be administered then a separate form should be used for each one.