# APPENDIX 1 – Parental Agreement to Administer Prescription or Non-prescription Medicine

**ST GABRIEL’S C OF E PRIMARY SCHOOL**

**Notes to Parent / Guardians**

Note 1: This school will only give your pupil medicine after you have completed and signed this form.

Note 2: All medicines must be in the original container as dispensed by the pharmacy, with the pupil’s name, its contents, the dosage and the prescribing doctor’s name as appropriate.

Note 3: The information is requested, in confidence, to ensure that the school is fully aware of the medical needs of your child.

**Prescribed/Non Prescribed Medication**

|  |  |
| --- | --- |
| Date |  |
| Pupil’s name |  |
| Date of birth |  |
| Class/Year Group |  |
| 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 schools reception staff |  |
| Time limit – please specify how long your pupil needs to be taking the medication |  day/s week/s |
| I give permission for my son/daughter to be administered non prescribed medication such as calpol, ibuprofen, hayfever relief |  |
| I give permission for my son/daughter to be administered the emergency inhaler held by the school in the event of an emergency | Yes / No/ Not applicable |
| 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 pupil |  |
| 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] if applicable |  |

I confirm that the medicine detailed overleaf has been prescribed by a doctor, and that I give my permission for the Headteacher (or a nominee) to administer the medicine to my son/daughter during the time he/she is at the 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)

