DCC PARENTAL AGREEMENT TO ADMINISTER PRESCRIPTION OR NON-PRESCRIPTION MEDICINE

Stoke Canon C of E Primary School

Notes to Parent / Guardians

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

Note 2: all medicines must either be in the original container as dispensed by the pharmacy, with your child's name, its contents, the dosage and the prescribing doctor's name (in the case of prescription medication) or in the original packaging (e.g. sealed blister pack) for non-prescribed medicine.

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

Medication details:

Date:	
Student's name:	
Date of birth:	
Group/class/form:	
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 Office	
Number of tablets/quantities 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 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

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I give permission for my son/daughter to carry their own asthma inhaler and manage its use	Yes / No / Not applicable
I give permission for my teenage son/daughter to carry their adrenaline auto injector for anaphylaxis (epi pen)	Yes / No / Not applicable
I give permission for my son/daughter to be administered the emergency adrenaline auto-injector held by the school in the event of an emergency	Yes / No / Not applicable
I give permission for my son/daughter to carry and administer their own medication in accordance with the agreement of the school and medical staff	Yes / No / Not applicable

Details of Person Completing this 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 ...*[name of staff]*.....	

I confirm that the medicine detailed overleaf has been prescribed by a doctor and that I give my permission for the Principal/Headteacher (or his/her nominee) to administer the medicine to my son/daughter.

I confirm that the medicine detailed is in the original packaging [in the case of non-prescription medication].

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.

Signature: _____ Date: _____
(Parent/Guardian/person with parental responsibility)