Form C - Parental consent for school to administer medicine (Prescription)

The school will not give your child medicine unless you complete and sign this form. Medication, with the *exception of travel sickness*, must be prescribed by a GP, labelled in the name of the child and the dosage must be **at least four times a day**. If more than one medicine is to be given a separate form should be completed for each one. **All medication must be handed in to the school office.**

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| --- | --- | --- |
| Name of school | Southway Junior School | Date: |
| Child’s Name |  |  |  |  | Date of Birth: |
| Year Group / Class |  |
| Medical Condition / Illness |  |
| Name and strength of medicine (as described on the container) |  |
| Expiry date |  | Keep refrigerated? Yes / No |
| How much to give *(i.e. dose to be given)* |  |
| When to be given (*time*)  |  | Self Administration? Yes / No |
| Special precautions / other instructions / side effects that school needs to be aware of |  |
| Number of days for medication to be administered  |  | Last dose to be given on: |
| Number of tablets / quantities provided |  |
| Procedure to take in an emergency |  |
| ***Note: Medicines must be in the original container as dispensed by the pharmacy and the manufacturer’s instructions and/or Patient Information Leaflet (PIL) must be included. Medication should be handed in to the school office and be clearly labelled with the child’s name and class.***  |
| Name of emergency contact |  |
| Phone number of emergency contact |  |
| Relationship to child |  |
| Name and phone number of GP |  |

* I accept that this is a service that the school is not obliged to undertake.
* The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school administering medicine in accordance with the school policy. I confirm that this medication has been administered to my child in the past without adverse effect. 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.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/carer) Please print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Form C1 - Parental consent for school to administer medicine (Non Prescription)

The school will not give your child medicine unless you complete and sign this form. Under exceptional circumstances where it is deemed that the administratton of non prescription medicine is required to allow the pupil to remain in school, the school will administer non prescription medication for a maximum of 48 hours. The medication cannot be repeated for 2 weeks after the initial episode and not for more than 2 episodes per term. Only one non prescription medication will be administered at a time. **All medication must be handed in to the school office.**

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| --- | --- | --- |
| Name of school | Southway Junior School | Date: |
| Child’s Name |  |  |  |  | Date of Birth: |
| Year Group / Class |  |
| Medical Condition / Illness |  |
| Name and strength of medicine (as described on the container) |  |
| Expiry date |  | Keep refrigerated? Yes / No |
| How much to give *(i.e. dose to be given)* |  |
| When to be given (*time*)  |  | Self Administration? Yes / No |
| Special precautions / other instructions / side effects that school needs to be aware of |  |
| Number of days for medication to be administered  |  | Last dose to be given on: |
| Number of tablets / quantity provided |  |
| Procedure to take in an emergency |  |
| ***Note: All medication should be handed in to the school office and be clearly labelled with your child’s name and class. It must be in its original packaging (with the manufacturers patient information leaflet), be suitable for the pupils age and have been administered to the child in the past without adverse effect. Medication that is sucked, i.e. cough sweets/lozenges will not be administered by the school.***  |
| Name of emergency contact |  |
| Phone number of emergency contact |  |
| Relationship to child |  |
| Name and phone number of GP |  |

* I accept that this is a service that the school is not obliged to undertake.
* The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school administering medicine in accordance with the school policy. I confirm that this medication has been administered to my child in the past without adverse effect. 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.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/carer) Please print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parental agreement for school to administer travel sickness medication

The school will not give your child travel sickness medication unless you complete and sign this form. Please provide a full box of medication to the school office, this will ensure that we have it available for all school trips that your child attends during this academic year. Travel sickness tablets will be given on the return journey of a school trip, the parent is responsible for giving the medication before school.

|  |  |  |
| --- | --- | --- |
| Name of school | Southway Junior School | Date: |
| Child’s Name |  |  |  |  | Class: |
| Date of Birth |  |
| Medical Condition | **Travel Sickness** |
|  |  |
| Name and strength of medicine |  |
| Expiry date |  |
| How much to give *(i.e. dose to be given)* |  |
| When to be given (*time required for the return journey*)  |  | Self Administration? Yes / No |
| Special precautions / other instructions / side effects that school needs to be aware of |  |
| Has the medication been given before? |  |
| Have there been any previous side effects that we need to be aware of? |  |
| Number of tablets / quantity provided |  |
| ***Note: Medicines must be in the original container and must be handed in to the school office. All medication should be clearly labelled with the child’s name and class. Travel sickness tablets must be in the original packaging (with the manufacturer’s instructions), be suitable for the pupil’s age and have been administered to the child in the past without adverse effect.*** |
| Phone number of emergency contact |  |
| Name / relationship to child |  |
| Name and phone number of GP |  |
| Agreed review date  |  (initiated by Welfare Officer) |

|  |  |
| --- | --- |
| My child will be wearing travel bands for all school trips and therefore does not require travel sickness medication |  |

|  |  |
| --- | --- |
| My child no longer suffers with travel sickness and therefore does not require travel sickness medication |  |

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* I accept that this is a service that the school is not obliged to undertake.
* The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school administering medicine in accordance with the school policy. I confirm that this medication has been administered to my child in the past without adverse effect. 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 give permission for the school to administer their own travel sickness medication (Kwells Kids) should a situation warrant it, i.e. tablets become out of date or travel bands have not been sufficient

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| Signature (parent/carer) |  |
| Print name |  |
| Date |  |

*Office use only:*

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Form B – Parent consent to administer short term non prescription ad hoc medicines

As per the Managing Medicines Policy, a small stock of standard paracetamol and antihistamine will be kept by the school for administration if symptoms develop during the school day. The school will not administer medication held on the school site unless this form is completed and signed. This information will be kept securely with your child’s other records.

If further information is needed we will contact you. Please do not hesitate to contact the school if there are any issues you wish to discuss.

|  |  |
| --- | --- |
| **Child’s Name** | **Date of Birth** |
| **Gender** | **Year Group / Class** |

Pupils will be given a standard dose suitable to their age and weight. If it is before 12.00 noon the school will contact you to confirm if medication has already been given. For further information on when medication can be given, please see the Managing Medicines Policy. You will be informed when the school has administered medication by email.

The school holds a small stock of the following medicines:

**Paracetamol (Calpol 6+) for the relief of pain, i.e. headache, migraine, period pain**

**Anti-histamine (Piriton) for mild allergic reaction. This will not be administered for hayfever symptoms; if your child suffers from hayfever please ensure that they have their medication before school.**

Tick the non-prescription medicines above that you give your consent for the school to administer during the school day and confirm that you have administered these medicines in the past without adverse effect. Please keep the school informed of any changes to this consent.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/carer) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/carer)

**Form D: record of medicine administered to an individual child (Controlled Drugs)**

|  |  |
| --- | --- |
| Name of school/setting |  |
| Name of child |  |
| Date medicine provided by parent |  |  |  |  |
| Group/class/form |  |
| Quantity received |  |
| Name and strength of medicine |  |
| Expiry date |  |  |  |  |
| Quantity returned |  |
| Dose and frequency of medicine |  |

Staff signature

Signature of parent

|  |  |  |  |  |  |  |  |  |  |
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| Date |  |  |  |  |  |  |  |  |  |
| Time given |  |  |  |
| Dose given |  |  |  |
| Controlled drug stock |  |  |  |
| Name of member of staff |  |  |  |
| Staff initials |  |  |  |
| Witnessed by |  |  |  |
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| Date |  |  |  |  |  |  |  |  |  |
| Time given |  |  |  |
| Dose given |  |  |  |
| Controlled drug stock |  |  |  |
| Name of member of staff |  |  |  |
| Staff initials |  |  |  |
| Witnessed by |  |  |  |

Form E – Record of medicine administered to all children

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| Name of school |  |

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| Date | Child’s name | Time | Name of Medication | Dose given | Any reactions | Signature | Print name | Comments |
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