**Parental agreement for Townley School/Pre-School to administer prescribed medicine**

The school **will not** give your child medicine unless this form is completed and signed. Parents/carers must provide the medicine in its original container and must have been dispensed by a pharmacist and have the label showing:

* Name of child:
* Name of medicine:
* Method of administration:
* The instruction leaflet with prescribed medicines should show:
* Any side effects
* Expiry date

|  |  |
| --- | --- |
| Date for review to be initiated by |  |
| Name of school/setting |  |
| Name of child |  |
| Date of birth |  |  |  |  |
| Group/class |  |
| Medical condition or illness |  |
| **Medicine** |  |
| Name/type of medicine*(as described on the container)* |  |
| Expiry date |  |  |  |  |
| Dosage and method |  |
| Quantity received |  |
| Timing |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school/setting needs to know about? |  |
| Self-administration – y/n |  |
| Procedures to take in an emergency |  |
| Quantity returned  |  | Date: |
| **NB: Medicines must be in the original container as dispensed by the pharmacy****Contact Details** |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| I understand that I must ensure an adult delivers the medicine personally to | [agreed member of staff] |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Name

Signature(s)

Date

Authorisation to administer medication approved by headteacher (or senior teacher)

Name

Signature(s)

Date

# Record of medicine administered

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| --- | --- |
| Townley official shield 2016 1 | Child’s name |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date00/00/00 | Time | Name of medicine | Dose given | Any reactions | Signature | Print name of staff | Witness Signature(controlled drugs) |
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