

**PARENTAL AGREEMENT TO ADMINISTER
PRESCRIPTION OR NON-PRESCRIPTION MEDICINE**

Winkleigh Primary School and Foundation Unit

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.

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 a member of staff. Medication should not be sent into school with the child.	
Number of tablets/quantity 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
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 carry and administer their own medication in accordance with the agreement of the Academy and medical staff	Yes / No / Not applicable

Details of Person Completing the 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 [named member of staff]	

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

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)



RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL YOUNG PERSON

Name of Establishment Winkleigh Primary School

Name of Young Person	
Date of Birth	
Tutor/ Class / group	
Date medicine provided by parent	
Name and strength of medicine	
Quantity received	
Dose and frequency of medicine	
Expiry date	
Quantity returned	

Staff signature _____ Initials _____

Log of Medicines Administered

Date	Time given	Dose given	Staff Name/Initials	Notes/ problems