**PARENTAL AGREEMENT TO ADMINISTER**

**PRESCRIPTION OR NON-PRESCRIPTION MEDICINE**

Hazeldown School

**Notes to Parent / Guardians**

Note 1: This school will only give your child medicine after you havecompleted 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 (eg: 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 t**he school office** |  |
| 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 |
|  |  |

**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 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 I also agree that I am responsible for collecting any unused or out of date supplies and that I will dispose of the supplies.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.

Parent’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian/person with parental responsibility)