**NORTH HEATH COMMUNITY PRIMARY SCHOOL**

**PARENT CONSENT TO ADMINISTER MEDICATION**

(where an Individual Healthcare Plan or Education Healthcare Plan is not required)

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

|  |  |
| --- | --- |
| Name of child |  |
| Date of birth |  |  |  |  |
| Class |  |
| Medical condition or illness |  |
| **Medicine** |  |
| Name/type of medicine*(as described on the container)* |  |
| Expiry date |  |  |  |  |
| Dosage and method |  |
| 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 |  |
| NB: 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**Contact Details**  |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| I understand that I must deliver the medicine personally to the School Office |

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 confirm that this medication has been administered to my child in the past without adverse effect. 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.

Signature(s) Date

**If this is a request to administer non-prescribed medication, please work with the school to complete Template C1 on the reverse of this form**

**Template C1**

**INDIVIDUAL PROTOCOL FOR NON-PRESCRIBED MEDICATION**

**This form should be completed in conjunction with Template C – parental consent**

Under exceptional circumstances where it is deemed that their administration is required to allow the pupil to remain in school the school will administer non-prescription medicines for a **maximum of 48 hours**.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date (requirement reviewed daily) | Time last dose administered at home as informed by parent/carer | Dosage given in school | Time | Comments |
| Day 1 |  |  |  |  |
| Day 2 |  |  |  |  |

|  |
| --- |
| 3 main side effects of medication as detailed on manufacturer’s instructions or PIL |
| **1.** | **2.** | **3.** |
|  |  |  |

**Emergency procedures** – if the pupil develops any of the signs or symptoms mentioned above or any other signs of reaction as detailed on the manufacturer’s instructions and/or PIL this might be a sign of a negative reaction or if it is suspected that the child has taken too much medication in a 24 hour period staff will call 999 and then contact the parent/carer(s).

I agree that the medical information contained in this plan may be shared with individuals involved with my child’s care and education.

I am aware that each day I must inform the school when I last administered the medication and that I will be informed by the school in writing when medication has been administered.

Agreed by: Parent/Carer………………………………………….………………..…. Date……………………………..

Template C1