

APPENDIX A

EXAMPLE FORM FOR PARENTS TO COMPLETE IF THEY WISH THE SCHOOL TO ADMINISTER MEDICATION.

The school will not give your child medicine unless you complete and sign this Form, and the Head teacher has agreed that school staff who volunteer to do so can administer the medication.

DETAILS OF PUPIL

Surname: _____

Forename(s): _____

Address: _____ M/F: _____

_____ Date of Birth: _____

_____ Class/Form: _____

Condition or illness: _____

MEDICATION

Name and strength of Medication (as described on the container): _____

Form (e.g. tablets, syrup, cream): _____

For how long will your child take this medication? _____

Date dispensed by pharmacist/doctor: _____

Full Directions for use:

Dosage and method to be taken: _____

Timing: _____

Special Precautions: _____

Details of any side effects: _____

Can your child self-administer? (See Appendix C) _____

Procedures to take in an Emergency: _____

CONTACT DETAILS:

Name: _____ Daytime Telephone No: _____

Relationship to Pupil: _____

Address (if different from Pupil's given above): _____

I understand that I must deliver the medicine personally to _____ [agreed member of staff] and accept that this service is provided by the relevant member of staff and the school/unit on a voluntary basis. I agree to inform the school of any changes to this information by completing a new form at the earliest opportunity.

Date: _____ Signature(s): _____

Relationship to pupil: _____