West Borough Primary School
Administration of Non Prescription Medicines in Schools Policy
- Appendix 4

Headteacher / Head of setting agreement to administer medicine where a Risk Assessment or Health Care Plan is not needed (Short Term Illness)

I give permission for a member of the school staff to administer medication to my child as follows:

Name of child: …… Class: ……..……

Date of Birth: …… Age: ……

Name of medication: ……

Where medicine is to be stored: …… Quantity Received: ……

Possible side effects: ……

Expiry Date: ……Dosage: …… Time to be given: ……

Medical condition/illness: ……..……

Date instruction is to commence on: …… until: …… (Maximum I week)

I understand that whilst the school will make every endeavour to carry out my request, I will not hold them liable if, for whatever reason, the medication is not administered as per my instruction.

If medicine is needed for more than I week, then we would recommend a doctor's appointment is made and any further medication to be prescribed by the GP.

Note : MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST. STUDENTS SHOULD NOT SELF ADMINISTER

If medicine is to be administered on an 'as and when needed' basis we will need to telephone a parent/carer **BEFORE** we are able to administer to ascertain if and when any medicine has already been administered at home. If it is difficult for us to be able to contact a parent during the day, then the parent **MUST** write in the child's contact book if any medicine has been given before school. We will then write a note in the book the date and time of the dose given.

Daytime contact number of parent or adult contact: ----------

Name and contact number of GP: ----------

This information is, to the best of my knowledge, accurate at time of writing and I give consent to the school / setting staff, to administer the 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.

Signed: ……(parent/guardian) Date: ……

Signed……(Headteacher / Staff) Date: ……

<u>Ensure:</u>
The right medicine for the right child at the right time at the right dose

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			
Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			