The school will not give your child medicine unless you complete and sign this form and the school will administer medicine according to the school policy.

|  |  |
| --- | --- |
| Date for review  |       |
| Name of school/setting | St Joseph’s Catholic Infant School |
| Name of child |       |
| Date of birth |       |       |       |  |
| Class/group/form |       |
| Medical condition or illness |       |
| **Medicine** |  |
| Name/type of medicine*(as described on the container)* |       |
| Expiry date |       |       |       |  |
| Dosage and method |       |
| When is medicine to be administered – time and situation |       |
| Special precautions/other instructions (including storage details eg fridge, locked cupboard if a controlled drug) |       |
| Are there any side effects that the school/setting needs to know about? |       |
| Self-administration – yes/no |       |
| Procedures to take in an emergency |       |
| Prescription/Non-Prescription(Tick as appropriate) | Prescription [ ]  | Non-prescription [ ]  |
| **NB: Medicines must be in the original container as dispensed by the pharmacy** **PLEASE TURN OVER** Image result for arrow symbol**Contact Details** |
| Name |       |
| Daytime telephone no. |       |
| Relationship to child |       |
| Address |       |
| I understand that I must deliver the medicine personally to | **School Office** |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school’s policy.

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 confirm that I have administered this medication,without adverse effect, to my child in the past. I will inform the school immediately, in writing, if my child subsequently is adversely affected by the above medication.

**If more than one medicine is required a separate form should be completed for each one**.

**Parent/Carer**

Signature(s)      Date

**For completion by the school/Headteacher**

I agree to arrange for the administration of medicine requested by the parent/carer.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_