**PARENTAL REQUEST FOR THE ADMINISTRATION OF MEDICINES IN SCHOOL**.

To be completed by the parent/guardian of any child requesting drugs/medication to be administered under the supervision of school staff, or where the child is bringing medicine into school which they will self administer.

Name of child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Group:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Name of Medicine.***  | ***Self administer?******Yes/No*** | ***When?*** | ***Amount?*** | ***How e.g mouth, ear drops etc.*** | ***Prescribed by doctor?******Yes/No*** |
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|  |  |  |  |  |  |
|  |  |  |  |  |  |

I request that the treatment be given in accordance with the above information by a named member of the school staff who has received all necessary training.

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent and that the school staff may, therefore, need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

Signed/Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Carer with Parental Responsibility

Emergency contact number today is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_