Lothersdale Primary School

REQUEST FOR / Record of medicine administered to an individual child

*If more than one medication is to be given, then a separate form must be completed for each*

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| TO BE COMPLETED BY THE PARENT/CARER | |
| **Name of School / Setting:** | LOTHERSDALE PRIMARY SCHOOL |
| **Name of child:** |  |
| **Class:** |  |
| **Medical condition/illness:** |  |
| **Medication name and strength:** |  |
| **Medication formula (eg. liquid/tablets):**  *Note: medication must be in the original container as dispensed by the pharmacy* |  |
| **Date medicine provided by parent/carer:** |  |
| **Dose and frequency/time of administration:** |  |
| **Details for storage:** |  |
| **Quantity received:** |  |
| **Administering instructions:** |  |
| **Any known side effects:** |  |

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| **PARENTAL STATEMENT OF CONSENT** | | | | |
| **I *(printed name of parent/carer)*** | |  | | |
| * request and give my consent to Lothersdale Primary School administering this medication in accordance with the prescriber’s instructions * confirm that the information and instruction given is accurate and up- to- date * will inform the school in writing of any changes to this information and instructions * understand that the medication may be given by non-medically qualified staff * agree to not hold staff responsible for loss, damage or injury when undertaking agreed administration of the medication unless resulting from their negligence * will abide by the school’s policy and procedure for the delivery and return of medication * will ensure adequate supply of the medication that is within its expiry date | | | | |
| **Parent/Carer Signature:** |  | | **Date:** |  |

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| **LOTHERSDALE PRIMARY SCHOOL STATEMENT OF AGREEMENT** | | | |
| Lothersdale Primary School agrees to administer this medication   * in accordance with the prescriber’s instructions * until the end of the course of medication or until instructed otherwise in writing by the parent/carer | | | |
| **Staff Signature:** |  | **Date:** |  |
| **Headteacher Signature:** |  | **Date:** |  |

**Note: The Headteacher must establish that the appropriate knowledge, training and insurance requirements for the giving of this medication are met before agreement is given.**

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| **RECORD OF MEDICINE ADMINISTERED BY STAFF TO AN INDIVIDUAL CHILD**  **(to be completed by the school)** |

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| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

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| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

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| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

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| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

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| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |