FORM 3

Parental agreement for setting to administer prescribed medicine

The setting will not give your child medicine unless you complete and sign this form, and the setting has a policy that staff can administer medicine

Name of Setting: **Christ Church CE Primary School**

Name of Child: _____

Date of Birth: _____

Group/Class/Form: _____

Medical condition/illness: _____

Medicine

Name the medicine is prescribed to on the container: _____

_____

Name /Type of Medicine (as described on the container): _____

_____

Date dispensed: _____

Expiry date: _____

Agreed review date to be initiated by: _____
[name of member of staff]:

Dosage and method eg Oral, inhaled: _____

Timing: _____

Special Precautions: _____

Are there any side effects that the setting needs to know about? _____

Self Administration (self administration form to be completed if yes): YES/NO ***(delete as appropriate)***

Procedures to take in an Emergency: _____

_____

_____

Contact Details

Name: _____

Daytime Telephone No: _____

Relationship to Child: _____

Address: _____

_____

_____

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the setting staff administering medicine in accordance with the setting policy. I will inform the setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I understand that I must deliver the medicine personally to [agreed member of staff] and accept that this is a service that the setting is not obliged to undertake.

Signature(s): _____

_____

Date: _____

Relationship to child: _____

If more than one medicine is to be given a separate form should be completed for each one

FORM 4

Confirmation of the Adult with a Duty of Care's agreement to administer medicine

Name of Setting: **Christ Church CE Primary School**

It is agreed that _____ *[name of child]* will receive _____ *[quantity and name of medicine]* every day at _____ *[time medicine to be administered eg Lunchtime or afternoon break].*

_____ *[name of child]* will be given/supervised whilst he/she takes their medication by _____ *[name of member of staff].*

This arrangement will continue until _____
[either end date of course of medicine or until instructed by parents].

Signed: _____

Date: _____

[*The Head of Setting/Named Member of Staff*]

FORM 5

Record of medicine administered to an individual child

Name of Setting: **Christ Church CE Primary School**

Name of Child: _____

Date medicine provided by parent: _____

Group/class/form: _____

Quantity received: _____

Name and strength of medicine: _____

Expiry date: _____

Quantity returned: _____

Dose and frequency of medicine: _____

Staff signature: _____

Parent signature: _____

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			