**MEDICINES IN SCHOOL**

This form must be completed by a parent or guardian before medicines can be administered in school by school personnel. All medicines must be in the original container as dispensed by the pharmacy and must be clearly labelled with the child’s full name and prescribed dosage.

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| Child’s Name: |  | Class : |  |

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| **MEDICATION :** |
| Name of prescribed medicine: |  |
| Expiry Date : |  |
| Possible Side Effects : |  |
| Storage : | Does this medicine need to be stored in a fridge : YES | NO |
| Reason for medication : |  |
| Date(s) to be administered :  | From : |  | To : |  |
| *Please note that we will only administer paracetamol / ibuprofen for a maximum of 3 days unless supported by a GP’s note.* |
| **DAILY DOSAGE :** |
|  1st Dosage : |  | Time : |  |
| 2nd Dosage : |  | Time : |  |
| **ADMINISTRATION :** |
| Method of Administration : | *eg : spoon / syringe* |
| SELF ADMINISTRATION :  | YES | NO |

I give consent for school staff to administer the above medicine/lotion/inhaler/epi-pen (supplied by me) to my child named above. I confirm that I am the parent / guardian for the above named pupil and accordingly I am legally empowered to give authority for the administration of this medicine. I understand that this a service that the school is not obliged to undertake.

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| Parent / Guardian Full Name :  |  |
| Signature: |  | Date: |  |