ADMINISTERING MEDICATION: PARENTAL PERMISSION FORM (to be completed by parents)			
PART A: DETAILS OF CHILD			
Surname		Forenames	
Address		M/F	
		Date of birth	
Reason for medication (condition/ illness)			
Does the child self administer? (please circle one)	YES NO (if yes please detail below further information and where the medication will be stored)		
PART B: CHILD'S MEDICATION DETAILS			
Name/type of medication (as described on the container)			
For how long will your child take this medication?			
When did your child last take this medication?			
Date dispensed			
Dosage and method			
Timing			
Special precautions			
Possible side effects			
Medication to be held by (please circle one)	CHILD	SCHOOL STAFF	
Medication to be (please circle one)	SELF-ADMINISTERED BY CHILD	GIVEN BY SCHOOL STAFF	

Procedures to take in an emergency			
Please detail any other medication that the child is currently taking			
Emergency contact details (two contacts must be provided)			
First contact			
Name			
Relationship to child			
Phone/mobile number			
Other contact number			
Address			
Second contact			
Name			
Relationship to child			
Phone/mobile number			
Other contact number			
Address			
I declare that my child has no adverse affects to this medication			
Signature (person with parental responsibility)		Date	
I/We acknowledge that the above instructions will be carried out by a member(s) of staff who is authorised to administer the medication. We also accept responsibility to arrange for the collection of unused medication at the end of each school year.			
Signature (person with parental responsibility)		Date	
Signature (student over 16 years of age)		Date	

RECORD OF ADMINISTERED MEDICATION (to be completed by school staff)					
Pupil's name			Staff designated to administer medication		
Name of medication					
Date	Time	Dose given (or reason why dose withheld)	Any reactions	Member of staff (print name)	Signature
Parents informed of last dose given					
Unused medication returned: Collected by parents Disposed of by school					

ADMINISTERING MEDICATION: SCHOOL AGREEMENT AND CONFIRMATION FORM (to be completed by school staff)			
I agree that (insert pupil's name)			
Will receive (insert quantity and dose of medication)			
Every day at (insert time medicine to be administered eg lunch time or break time)			
Your child will be: (*please delete as appropriate*) Given their medication to self administer Supervised while he/she takes their medication by (print name of member of staff):			
The arrangements will continue until (insert either end date of course of medication or until instructed by parents)			
Signed:Named Staff		Date	
Signed:Headteacher		Date	

RECORD OF ADMINISTERED MEDICATION (continued)					
Date	Time	Dose given (or reason why dose withheld)	Any reactions	Member of staff (print name)	Signature