**Appendix 4A – Administering Medication: Parental Permission Form**

To be reviewed at the beginning of each term as a minimum and any changes to medication recorded immediately as required. There should be a separate form for each prescribed medication.

Medication no longer needed to treat the condition it was prescribed or purchased for, or which is out of date, should be returned to the parents/carers.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | **DATE:** | | |
| **PART A: DETAILS OF CHILD** | | | | | | |
| Surname |  | | Forenames | |  | |
| Address |  | | Male/Female | |  | |
| Date of birth | |  | |
| Reason for medication (condition/illness)  Signs and symptoms displayed | | | | | | |
|  | | | | | | |
| 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 and strength *as stated on the dispensing/product label*  E.g. 500mg or 5mg/10ml  Staff should always read and retain the information leaflet which is supplied when a medicine is dispensed by a dispensing doctor, at a pharmacy or bought over the counter | |  | | | | |
| Date medicine dispensed | |  | | | | |
| Expiry Date of medication | |  | | | | |
| Form of the medicine  E.g. capsule, tablet, liquid | |  | | | | |
| Quantity of medicine received | |  | | | | |
| Storage of medication (Medication should always be supplied to the service in its original container and box clearly labelled with  the child’s name.) | |  | | | | |
| Dosage | |  | | | | |
| Dosage instructions  E.g. one tablet to be taken 3 times a day | |  | | | | |
| Time medication is to be administered  If medication is to be administered ‘as and when required’ please indicate the signs, symptoms and/or conditions for giving medication. | |  | | | | |
| How long will your child take this medication for? | |  | | | | |
| Please confirm your child has been given the first dose of this medication at home where possible  This may not include emergency medication such as an adrenaline pen. | | Yes/No  Date: Time:  Any side effects noted? (Please detail) | | | | |
| When did your child last take this medication? | |  | | | | |
| Special precautions | |  | | | | |
| Possible side effects | |  | | | | |
| Medication to be held by  *(please circle one)* | | child | | | | staff |
| Medication to be  *(please circle one)* | | self-administered by child | | | | given by staff |
| **Signs and Indicators that would constitute an emergency situation** | |  | | | | |
| **Procedures to take in an emergency (detail in full)**  Individual flow charts for children are helpful in detailing actions for staff- these should be provided by NHS where appropriate | |  | | | | |

|  |  |  |
| --- | --- | --- |
| 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 |  |  |
| Telephone/mobile number |  |  |
| Other contact number |  |  |
| Address |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Second contact** | | | | |
| Name | |  | | |
| Relationship to child | |  | | |
| Telephone/mobile number | |  | | |
| Other contact number | |  | | |
| Address | |  | | |
| **I declare that my child has no adverse effects 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. | | | | |
| Signature (person with parental responsibility) |  | | Date |  |
| Signature  (student over  16 years of age) |  | | Date |  |

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| **Pupils who have asthma and are prescribed an inhaler** | | |
| (Please circle one)  My Child has asthma and **has an asthma action plan** - please see copy enclosed  My child has asthma and/or a reliever inhaler has been prescribed but **does not have an asthma action plan** | | |
| Signature (person with parental responsibility) |  | Date |