

Parental Request for <u>Self-Administration</u> of Medication			
To:	The Head teacher		
School:			
I wish my son/daughter, when necessary, to be permitted to take the following medicine(s) and/or perform the following clinical test(s)			
<u>Name of child/young person</u>	<u>Date of Birth</u>	<u>Class/Teacher</u>	<u>Date request made</u>
Name of medical condition			
Details of medicine(s) and/or test(s)			
<u>Name of medicine(s) or test(s)</u>	<u>Dosage</u>	<u>Time to be administered (am/pm)</u>	<u>Only as required (tick)</u>
A			
B			
C			
Please indicate the circumstances in which the medicine(s) or test(s) will be administered and action to take if the child/young person refuses			
Please delete statements as appropriate:			
<input type="checkbox"/> Medication stored by school <ul style="list-style-type: none"> <li>It is/It is not necessary for a member of staff to record each dose of medicine and/or each test performed</li> <li>My son/daughter will alert staff when medication is required</li> </ul>		<input type="checkbox"/> Medication carried by Child <ul style="list-style-type: none"> <li>My son/daughter will carry the above medicine(s) at all times, for taking as required.</li> <li>It is not necessary for a member of staff to record each dose of medicine and/or each test performed</li> </ul>	
I understand that: <ul style="list-style-type: none"> <li>I will undertake to deliver the medicine(s) and/or test materials personally to school, and to replace them whenever necessary if my child is not carrying the medication</li> <li>I will advise you immediately of any changes in treatment prescribed by doctor or hospital.</li> <li>I must confirm that the <b>First Dose</b> of the medication has been given at home- <b>Excluding Emergency Medication</b></li> <li>Staff within the school take responsibility for this on a voluntary basis and cannot take responsibility when my child/young person refuses to take medication</li> </ul>			
Signed by:	Relationship to child/young person:		Date:
Parent/Carer:			
School:			

RECEIPT OF MEDICATION FOR CHILD			
Name of medicine	Date received in school	Expiry Date	
Total amount of drug received (in mls, no. of tablets or units)			

Name of school:	Signature of staff member	Countersignature of 2 <sup>nd</sup> staff member

RECEIPT OF MEDICATION FOR CHILD			
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Total amount of drug received (in mls, no. of tablets or units)			

Name of school:	Signature of staff member	Countersignature of 2 <sup>nd</sup> staff member

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Please note that medication stored in schools will not be available outwith normal school hours.

Parents and carers must contact their GPs for the replacement of medication required outwith normal school hours and terms e.g., out of school clubs