APPENDIX 8

Education Services

Glasgow CITY COUNCIL

Parent/Carer Instructions for Long/Short Term

Administration of Medicines

PLEASE USE BLACK INK AND BLOCK LETTERS

1	Name of Child/Young Person
	Name of medicine
	Dose or doses
	Time(s) of day to be given
2	Name of family doctor
	Address of family doctor
	Phone number of family doctor

Signature of parent/carer _____ Date _____

Signature _____ Date _____

Blairdardie Primary – administration of medicine

I.....(insert name) understand the conditions under which my child's medication will be admistered, namely:

- No member of school staff has medical training beyond first-aid
- My child will be supervised, but will take the medication themselves
- It is my responsibility to ensure no medication provided has passed it's expiry date
- It is my responsibility to inform the school of any changes to this information as soon as it is available to me.

Signed.....parent/guardian Date.....

Member of Staff receiving the medication and form for the pupil

Signature..... Date:.....

Glasgow CITY COUNCIL

Record of Drug Administration

PLEASE USE BLACK INK AND BLOCK LETTERS

Name of Child/Young Person

Date	Time (24 hour)	Name of drug/medicine	Dosage(s)	Signature of member of staff administering drug	Witnessing member of staff