PERTH & KINROSS COUNCIL
Education & Children's Services

APPENDIX 1
PR

Parental Request for Medication to be Administered

1. YOUNG PERSON'S DETAILS

Name: ..... Date of Birth: .....

Address: .....

.....

School: .....

Tel. No: Home: ..... Emergency: .....

2. DETAILS OF MEDICATION/MEDICAL CONDITION

I wish my son/daughter to have the following prescribed medication administered by staff as indicated:

A Nature of medical condition: .....

B Name of medicine(s): .....

C Prescribed by (please tick as appropriate):

General Practitioner ☐	Hospital ☐	Other ☐
Name	Name	Specify .....
Address	Address	Address .....
.....	.....	.....

N.B. Written instructions from a medical professional are required

D Times at which medicine(s) to be given
(please specify times or **as required**)

.....

E Dose of medicine(s) to be given and means of administration

.....

PR
Continued

F Length of time current supply of medicine will cover

.....

G Any special precautions required

.....

H Any possible side effects

.....

NB Staff are not required to administer medication. You may be required to sign an agreement for the implementation of an individual pupil protocol in certain circumstances. The Headteacher will give you details and information of this if required.

3. STAFF INDEMNITY

The Local Authority hereby indemnifies and holds harmless all staff at the school from, and against all actions, costs, charges, losses, damages and expenses which they or any of them shall or may incur or sustain by reason of any act or omission by them, in the administration of the medication to the Pupil, provided always that the member of staff has acted within the remit of their authority and without malice.

4. PARENTAL RESPONSIBILITY

(i) I accept responsibility for delivering the medicine(s) personally to you, and to replace them wherever necessary.
(ii) I accept responsibility for ensuring that medication is correctly labeled and has not passed any 'use by' date.
(iii) I accept responsibility for advising you immediately of any change of treatment prescribed by any doctor or hospital.
(iv) I understand the terms of the Staff Indemnity.

Signature: ..... Date: .....
Parent/Carer

Date received by Establishment: ..... Signature: .....
Head of Establishment

ACTION TAKEN