**Loch Insh Trip 2019**

**REQUEST FOR SCHOOL TO ADMINISTER MEDICATION**

**The staff will not give your child medicine unless this form is completed and signed. Please note that staff will not administer the first dose of a medication that is new to the child. This is in line with publication HCR-0514-087 from the Care Inspectorate.**

## PUPIL INFORMATION:

Pupil’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ \_\_\_\_ Class: \_\_ \_

Address: \_\_ \_

Condition or Illness:

Name of Medication (as described on container) \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how long will your child take this medication? \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date dispensed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please sign the statement below if applicable:*

*This medication is new to my child and he/she has previously received a dose of it.*

*Signature ..................................................................................................*

FULL DIRECTIONS FOR US

Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Timing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route eg Oral, injection etc\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side Effects \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

Self Administration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedures to take in an emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Pupil\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daytime phone number \_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I understand that:***

***1 I must deliver the medicine personally to the School Office.***

***2 If no member of staff who is trained to give medication is available then the medication will not be given and I will be informed.***

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

##### THIS PART OF THE FORM IS TO BE COMPLETED BY THE SCHOOL

**Confirmation of the Head Teacher’s agreement to administer medication**

I agree that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will receive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* (insert name and amount of

medication) every day at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*(Insert Time – eg break, lunchtime)

This arrangement will continue until\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (end date of course)

If a member of staff who is trained to give this medication is not available for any reason, the medication may not be given and the parent will be informed.

**Signature (Head Teacher)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

###### Name of Pupil \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### RECORD OF MEDICATION ADMINISTERED

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Time** | **Dose** | **Any reaction / refusal****(please comment)** | **Signature of staff member** | **Print name** |
|  |  |  |  |  |  |