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| **Shetland Islands Council** **Children’s Services****Head Teacher:** **Mrs A-M Angus****Sound Primary School****Lerwick****Shetland****ZE1 0LY****01595 744982****sound@shetland.gov.uk****www.sound.shetland.sch.uk** ***Working together to improve outcomes for learners to be the best that they can be.*** |

##

**Parental Request for Staff to Administer Medication**

*Sound School and Nursery will not give your child medicine unless this form is completed and signed*

Surname of pupil……………….………………………..……….. Forename(s)……………………………….………………..

Address…………………………………………………………………...…………………………………..………………………

M/F…….…..….. Date of Birth…………………….………….……………… Class…………………………….…….………..

Condition or illness…………………………………….…………………………………..……………………….………………..

Name/Type of Medication (*as described on the container*)..……………………………………..……….…………………….

Form of medication *(e.g. tablet, liquid, cream*): …………………………………………………………………………………..

For how long will your child take this medication? ………………………………………..………...………………………….

Date dispensed………………………………………………………………………………………………………..……………..

Dispensing label Information leaflet *(Please tick to show that school has received these.)*

**FULL DIRECTIONS FOR USE**

Dosage…………………………………..………………………………………………………………………………...………….

Timing………………………………………………………………………………………………………………………..………..

Route e.g. oral, injection etc.......………………………………………………………………………………….………………..

Side Effects…………………………………………………………………………………………………...………………………

Self Administration………………………………………………………………………………………………………...……...….

Procedures to take in an emergency ..…………………………………………...………………………….……………………

Emergency contact name…………………………………….……………………………………………...……………………...

Relationship to pupil ……………………………….…………. Daytime phone no. …………………………..….……………

Address …………………………………………………………………………..…….……………………………………………

Please read and sign this declaration;

 **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(s)…………………………………………………………….……………………. Date……………………..…………

Relationship to pupil…………………………………………………………………….……………………………………………

**Record of medication administered**

***To be completed by Staff***

Surname of pupil……………….………………………..……….. Forename(s)……………………………….………………..

M/F…….…..….. Date of Birth…………………….………….……………… Class…………………………….…….………..

Name/Type of Medication (*as described on the container*) .……………………………………..……….……...…………….

Head Teacher Signature ..……………………………………..………..……………….… Date ………………………………

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| Date and TimeAdministered | Reason | Dose Given | Any adverse reaction  | Signature of adult administering | Shared with Parent/Carer and How – Email/Face to Face/Phone | Date Shared | Staff Signature |
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