Parent/Carer Request for Administration of Medication **Date……/……../…….**

Dear Parent

Administration of Medicines and Meeting Children's Health Care Needs in School.

You have requested that your son/daughter - ……, be given Medicine at school. I would be grateful if you could sign the form below and return it to me to allow us to do this.

Yours Sincerely

Acting Headteacher

Administration of Medicines and Meeting Children's Health Care Needs in School at school

School/Parent Agreement

I request that my son/daughter: ……Class:……

- Medicine: _____
- Dose: _____
- Method of administration: _____
- Type of Allergy: _____
- Possible side effects: _____
- My child requires assistance to administer their asthma inhaler YES or NO (Please Circle)
- My child is able to take responsibility and carry their own asthma inhaler during the school day YES or NO (Please Circle)
- Asthma Triggers: _____
- Possible side effects: _____
- Frequency:_____
- Times to be taken: _____
- Name of doctor/prescriber: _____

Signed:……Contact Number …… Date:……..

Agreed: ……(Headteacher) Date:……..

Record Card

Name	DOB	Tel No	GP	GPs Tel No
		Home: Emergency:		
Medicine	**Details**	**Dose**	**Additional Instructions**	**Staff Member(s) Responsible**
			ROUTE CODES	**1**
			O orally **NG** nasogastric	
			G gastrostomy **INH** inhaled	**2**
			TOP topically **B** Buccal	

Date	Time	Exp	Signatures	Date	Time	Exp	Signatures

- Exp date of expiration on medication