A picture containing clothing

Description automatically generated

**PARENTAL AGREEMENT TO ADMINISTER**

**PRESCRIPTION MEDICINE**

**St Catherine’s Catholic Primary School**

**Notes to Parent / Guardians**

Note 1: This school will only give your child medicine after you havecompleted and signed this form.

Note 2: All medicines must either be in the original container as dispensed by the pharmacy, with your child’s name, its contents, the dosage and the prescribing doctor’s name.

Note 3: This information is requested, in confidence, to ensure that the school is fully aware of the medical needs of your child.

**Medication details**

|  |  |  |
| --- | --- | --- |
| Date |  | |
| Pupil’s name |  | |
| Date of birth |  | |
| Class/year |  | |
| Reason for medication |  | |
|  | | |
| Name / type of medicine  (as described on the container) | |  |
| Expiry date of medication | |  |
| How much to give (i.e. dose to be given) | |  |
| Time(s) for medication to be given | |  |
| Special precautions /other instructions  (e.g. to be taken with/before/after food) | |  |
| Are there any side effects that the school needs to know about? | |  |
| Procedures to take in an emergency | |  |
| I understand that I must deliver the medicine personally to the school office | |  |
| Number of tablets/quantity to be given | |  |
| Time limit – please specify how long your student needs to be taking the medication | | \_\_\_\_\_\_\_\_day/s \_\_\_\_\_\_\_\_week/s |

**Details of Person Completing the Form:**

|  |  |
| --- | --- |
| Name of parent/guardian |  |
| Relationship to pupil |  |
| Daytime telephone number |  |
| Alternative contact details in the event of an emergency |  |
| Name and phone number of GP |  |
| Agreed review date to be initiated by………………………………………………………. |  |

I confirm that the medicine detailed has been prescribed by a doctor and that I give my permission for the school to administer the medicine to my son/daughter.

I confirm that the medicine detailed is in the original packaging

I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. I also agree that I am responsible for collecting any unused or out of date supplies and that I will dispose of the supplies.

The above information is, to the best of my knowledge, accurate at the time of writing.

Parent’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian/person with parental responsibility)