**Administration of medication in school**

|  |  |
| --- | --- |
| Full Name of Child/Young Person: | |
| Date of Birth: | |
| Name of person completing this form: | |
| Relationship to student: | |
| Doctor prescribing the medication: *(inc. name, role, address etc.)*  *Allergies:* | |
| Name of Medications: | |
| Purpose/reason for medication: | |
| Route/Method: *(e.g. tablet, syrup, powder etc.)* | |
| Dose 1: | Time: |
| Dose 2: | Time: |
| Dose 3: | Time: |
| Any special instructions or advice: | |
| Possible side-effects or adverse reactions | |



**Administration of Medication in School**

Declaration:

The information I provide on this form is, to the best of my knowledge, accurate and complete.

I give consent to suitably trained Springhead School Staff to administer the medication detailed overleaf to my son/daughter in accordance with policy and good practice.

I will always supply prescription medication which is:

In date

In its original container

Clearly labelled as dispensed by a Pharmacist

I will always supply non-prescription medication which:

In date

In its original container

Contains the manufacturer’s instructions

I accept that school staff will administer non-prescription medication in accordance with manufacturer’s instruction only.

I will ensure the medication is always passed ‘staff to staff’; and never left in possession of my child.

I will inform the school immediately, in writing, if there are any changes to my child’s medication and understand that I must supply an amended authorisation form in the event of changes.

I will inform the school if the medication is to cease.

I understand that Springhead School is obliged to administer medications in accordance with best practice, policy and legal requirements; and that staff may not be able to administer medications without full written consent.

Signature:

Print Name:

Date: