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**ADMINISTRATION OF TEMPORARY MEDICATION FORM (Form 3)**

Parental agreement form giving permission for Elmlea Schools’ Trust staff to administer temporary medicine. Without this authorisation, the school is unable to administer medication. One form to be completed for each type of medication.

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| **CHILD’S DETAILS** |  |
| Name of child |  |
| Child’s address including postcode |  |
| Class |  |
| Date of Birth |  |
| Medical condition or illness |  |
| **MEDICINE: Medicines must be in original container with label as dispensed by pharmacy plus official**  **information leaflet included which parents must have read and understood.** | |
| Name of medicine  (as described on the container) |  |
| Type of medicine E.g. tablet/capsule/liquid/  Inhaler etc |  |
| Strength of medicine  (as described on the container) |  |
| Expiry date of medication |  |
| Date and time first dose given. School will not  administer first dose of any medication with the  exception of an auto adrenaline injector |  |
| Date of last dose to be administered in school |  |
| Dosage and method |  |
| Time(s) to be given |  |
| Special precautions/other instructions/  storage information |  |
| Are there any side effects that the  school should know about? |  |
| Self-administration | Yes/No (delete as appropriate) |
| Describe what constitutes an emergency for  the pupil/procedure to take |  |
| **CONTACT DETAILS OF PARENT/GUARDIAN COMPLETING FORM** | |
| Relationship to child |  |
| Name |  |
| Priority telephone number |  |
| Alternative contact number |  |
| Address including postcode if different to child |  |
| **DECLARATIONS** | |
| PARENT/GUARDIAN | |
| Name of child: | |
| My child’s medication is in its original container with label as dispensed by pharmacy plus official  information leaflet included which I have read and understood to the best of my ability.  Yes/No (delete as appropriate) | |
| I understand that I, or a named adult must deliver the medicine safely to the School Office and arrange its  collection and safe disposal. Yes/No (delete as appropriate) | |
| I am responsible for supplying in date medication to school and arranging for new medication to be supplied  when it has passed its use by date. Yes/No (delete as appropriate) | |
| I give permission for this information to be circulated to the appropriate members of staff.  Yes/No (delete as appropriate) | |
| The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to  appropriately trained school staff administering medicine in accordance with the school policy. School will NOT  be giving the first dose (with the exception of an auto adrenaline injector). Yes/No (delete as appropriate) | |
| 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. In the event of any difficulties one of the above contacts can be contacted at all times  during the school day on the telephone numbers listed above. Yes/No (delete as appropriate) | |
| I understand that the school will contact me before administering some prescribed medications to ascertain when the last dose was taken. e.g. anti-histamines/ paracetamol/ibuprofen. Yes/No (delete as appropriate) | |
| Parent’s signature |  |
| Print name |  |
| Date |  |
| SCHOOL | |
| The school will contact parents before administering certain medications e.g. anti-histamines/  paracetamol/ibuprofen to ascertain when the last dose was taken. | |
| Office Staff will arrange for medication to be taken with the Staff Trip Lead when a child goes off site as per  school policy | |
| If child refuses medication or if anything of note occurs during the administration parents will be informed. | |
| Date medication received in Office |  |
| Confirmed that the medicine/container is clearly marked with the name of the medicine, pupils name, dosage of the drug, including method of administration and frequency of administration | YES/NO |
| Special storage requirements noted | YES/NO/N/A |
| Is Risk Assessment required | YES/NO |
| Signed (Member of Staff) |  |
| Name |  |
| Job title |  |
| Date |  |