London Borough of Havering

ENGAYNE PRIMARY SCHOOL

Mrs S Sankey: Headteacher

01708 223492

Parental Request for non – prescribed medications to be administered

The need for medication to be administered to pupils during school hours must be supported by a parent or guardian's written request.

It is also important to keep the administration of medication to a minimum and parents are requested to consider the possibility of administering the daily doses out of school hours(If the medication requires 3 doses per day, please administer outside of school hours). If this is not possible, the following consent form must be completed:

To: Mrs Sankey

I wish my child (name) ________________________________Class________
to have the following medicine administered by school staff as indicated:

Name of Medication ______________________

For how long will your child require this medication ______________________

Time at which to be given ______________________________

Means of administration ______________________________

Reason child needs medication during school hours ______________________

____

Signed ______________________ Relationship to child ____________________

....

FOR SCHOOL USE ONLY

Permission granted by member of SLT: YES / NO until (date) ____________________

Signed: ______________________ Date:____________________

Name (Printed) ____________________

PLEASE COMPLETE BOTH SIDES.

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FORM 3B

Parental agreement for school to administer medicine

It is important to keep the administration of medication to a minimum and parents are requested to consider the possibility of administering the daily doses out of school hours (If the medication requires 3 doses per day, please administer outside of school hours). If this is not possible the following consent form must be completed

The school will not give your child medication unless you complete and sign this form, and the school has a policy that staff can administer medicine.

Name of School: Engayne Primary School

Date: ______________________________

Child's name: ______________________________

Class: ______________________________

Name and Strength of medicine: ______________________________

Administration dates START ______________ END ______________

(Please make sure you collect any remaining medicine from the school office on the end date. If medication has not been picked up within a week, the school will dispose of it at the local pharmacy.)

EXPIRY DATE of MEDICATION ______________________________

DOSE ______________________________

TIMES TO BE GIVEN ______________________________

Number of tablets/quantity to be given to school: ______________________________

(Where available, please give medication in individual doses – eg calpol sachets)

NOTE: MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY.

If the medication is NOT prescribed, please confirm that you have checked that the original label states that the medication is suitable for the age of your child: YES / NO (please circle)

Daytime phone number: ______________________________

Name and phone number of GP ______________________________

Agreed review date: ______________________________

The above information is to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

PARENT/ CARER'S SIGNATURE ______________________________

PRINT NAME: ______________________________

DATE: ______________________________