PARENTAL AGREEMENT TO ADMINISTER MEDICINE

St James School

Notes to Parent / Guardians

Note 1: This academy will only give your student medicine after you have completed and signed this form.

Note 2: All medicines must be in the original container, with the student's name, its contents, the dosage

Note 3: The information is requested, in confidence, to ensure that the academy is fully aware of the medical needs of your student.

Prescribed Medication

Date	
Student's name	
Date of birth	
Group/class/form	
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 academy needs to know about?	
Procedures to take in an emergency	
I understand that I must deliver the medicine personally to *St James Reception staff*	
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
I give permission for my son/daughter to be administered the emergency inhaler held by the school in the event of an emergency	Yes / No/ Not applicable
I give permission for my son/daughter to carry their own asthma inhalers	Yes / No / Not applicable
I give permission for my son/daughter to carry their own asthma inhaler and manage its use	Yes / No / Not applicable
I give permission for my teenage son/daughter to carry their adrenaline auto injector for anaphylaxis (epi pen)	Yes / No / Not applicable
I give permission for my son/daughter to carry and administer their own medication in accordance with the agreement of the Academy and medical staff	Yes / No / Not applicable

Details of Person Completing the Form:

Name of parent/guardian	
Relationship to student	
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 [named member of staff]	

I confirm that I give my permission for the Headteacher (or her nominee) to administer the medicine to my son/daughter during the time he/she is at the Academy.

I will inform the academy 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 I also agree that I am responsible for collecting any unused or out of date supplies and that I will dispose of the supplies.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)

PARENTAL AGREEMENT TO ADMINISTER MEDICINE

SCHOOL TRIPS ONLY

St James School

Notes to Parent / Guardians

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Prescribed Medication

Date	
Student's name	
Date of birth	
Group/class/form	
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 academy needs to know about?	
Procedures to take in an emergency	
I understand that I must deliver the medicine personally to *Academy Reception staff*	
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
I give permission for my son/daughter to be administered the emergency inhaler held by the school in the event of an emergency	Yes / No/ Not applicable
I give permission for my son/daughter to carry their own asthma inhalers	Yes / No / Not applicable
I give permission for my son/daughter to carry their own asthma inhaler and manage its use	Yes / No / Not applicable
I give permission for my teenage son/daughter to carry their adrenaline auto injector for anaphylaxis (epi pen)	Yes / No / Not applicable
I give permission for my son/daughter to carry and administer their own medication in accordance with the agreement of the Academy and medical staff	Yes / No / Not applicable

Details of Person Completing the Form:

Name of parent/guardian	
Relationship to student	
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 [named member of staff]	

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