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| Parental Agreement to Administer Prescription orNon-prescription Medicine **Collaton St Mary Primary School**  **Notes to Parent/Guardians**  Note 1: This school will only give your pupil medicine after you have completed and signed this form.  Note 2: All medicines must be in the original container as dispensed by the pharmacy, with the pupil’s name, its contents, the dosage and the prescribing doctor’s name as appropriate.  Note 3: The information is requested, in confidence, to ensure that the school is fully aware of the medical needs of your child. This information will be kept in accordance to GDPR Regulations.  **Prescribed/Non Prescribed Medication**   |  |  | | --- | --- | | Date |  | | Pupil’s name |  | | Date of birth |  | | Class/Year Group |  | | Reason for medication |  | | Name/Type of medicine  (as described on the container) |  | | Expiry date of medication |  | | Dosage to be given |  | | Time(s) for medication to be given |  | | Special precautions/other instructions  (e.g. to be taken with/before/after  food/kept in fridge) |  |   PTO   |  |  | | --- | --- | | Are there any side effects that the school needs to know about? |  | | Time limit – please specify how long your pupil needs to be taking the medication | day/s week/s | | I give permission for my son/daughter to be administered non prescribed medication such as calpol, ibuprofen, hayfever relief |  | | 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 |   **Details of Person Completing the Form:**   |  |  | | --- | --- | | Name of Parent/Guardian |  | | Relationship to pupil |  | | Contact telephone number |  |   I confirm that the medicine detailed overleaf has been prescribed by a doctor and that I give my permission for a member of staff to administer the medicine to my son/daughter during the time he/she is at the School **OR**  I confirm that the non-prescribed medicine detailed overleaf is suitable for my child and I give permission for a member of staff to administer the medicine to my son/daughter during the time he/she is at the School.  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/Guardian Signature Date | Parental Agreement to Administer Prescription orNon-prescription Medicine **Collaton St Mary Primary School**  **Notes to Parent/Guardians**  Note 1: This school will only give your pupil medicine after you have completed and signed this form.  Note 2: All medicines must be in the original container as dispensed by the pharmacy, with the pupil’s name, its contents, the dosage and the prescribing doctor’s name as appropriate.  Note 3: The information is requested, in confidence, to ensure that the school is fully aware of the medical needs of your child. This information will be kept in accordance to GDPR Regulations.  **Prescribed/Non Prescribed Medication**   |  |  | | --- | --- | | Date |  | | Pupil’s name |  | | Date of birth |  | | Class/Year Group |  | | Reason for medication |  | | Name/Type of medicine  (as described on the container) |  | | Expiry date of medication |  | | Dosage to be given |  | | Time(s) for medication to be given |  | | Special precautions/other instructions  (e.g. to be taken with/before/after  food/kept in fridge) |  |   PTO   |  |  | | --- | --- | | Are there any side effects that the school needs to know about? |  | | Time limit – please specify how long your pupil needs to be taking the medication | day/s week/s | | I give permission for my son/daughter to be administered non prescribed medication such as calpol, ibuprofen, hayfever relief |  | | 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 |   **Details of Person Completing the Form:**   |  |  | | --- | --- | | Name of Parent/Guardian |  | | Relationship to pupil |  | | Contact telephone number |  |   I confirm that the medicine detailed overleaf has been prescribed by a doctor and that I give my permission for a member of staff to administer the medicine to my son/daughter during the time he/she is at the School **OR**  I confirm that the non-prescribed medicine detailed overleaf is suitable for my child and I give permission for a member of staff to administer the medicine to my son/daughter during the time he/she is at the School.  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