LIGHTLCIFFE CE PRIMARY SCHOOL

MEDICINE IN SCHOOL

I would like my son / daughter to be given medicine in school as detailed below:
(ONLY MEDICINE PRESCRIBED BY A DOCTOR)

Name …… Class……..……..

Date of Birth……

Medical Condition or Illness……

Time of Last Dose……

Name of medicine to be administered……

Has this been prescribed by a doctor? Y / N

Date dispensed…… Expiry date……

Dosage to be given…… Time dose to be administered……..…..

Any side effects school needs to be aware of:……
……

Contact details:

Name and relationship to child……

Daytime contact number……

Address……

I understand that I must deliver and collect the medicine personally to and from the school office

I accept that this is a service that the school is not obliged to undertake.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicines 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 medicine is stopped. I understand that Lightcliffe CE Primary School does not accept any liability for failure to administer the medicine as stated above.

Date…… Parent signature……

Agreed by Headteacher/named First Aider on:

Date…… Signed……

Lightcliffe CE (VA) Primary School
RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL PUPIL

Name of Pupil:.....

Staff administering medicine — please complete chart below after each dose

Date					
Name of Medication (see over)					
Dose Given (see over)					
Time Given					
Name of member of staff					
Staff initials					

Signed…….. Date……..

Relationship to child named above……..