Hampstead Hill School

Respect. Kindness. Community. Curiosity. Conservation.

Parental Request for Medication to be Administered in School

Pupil Details

Pupil's Name: _____ Date of Birth: _____

Home Address: _____

_____ Phone Number: _____

Year Group: _____ Class: _____ Emergency Tel: _____

Medical Details

I request and give my consent for my son/daughter to have the following prescribed medication administered by school staff as indicated:

Nature of medical condition: _____

_____

Name of medicine(s): _____

_____

Medicine prescribed by (circle one): General Practitioner / Hospital Consultant / Other

Name: _____ Position: _____

Practice/Hospital/Other Address: _____

_____ Department (if applicable): _____

Times at which medicine(s) to be given: (please specify time or 'as required'):

_____

_____

Dose of medicine(s) to be given and means of administration:

_____

_____

Length of time current supply of medicine(s) will cover and expiry date:

_____

_____

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Emergency Contact Details

Name: _____ Parent / Carer (circle one)

Mobile Tel: _____ Work/Other Tel: _____

Other Emergency Contacts: (please provide GP's details and at least ONE other contact)

GP's Name: _____ Tel: _____

Name: _____ Tel: _____

Name: _____ Tel: _____

Prior usage of medication/previous doses given

If several doses of medicine are due in a 24hr period, please endeavour to give one dose before school and one dose after school – please record all doses given at home below and return the form to school daily.

Date	Time Given	Medicine & Dosage	Given by (name/position)

Parental Responsibility

1. I accept responsibility for delivering the medicine(s) personally to the Headteacher or nominated member of the promoted staff, and to replace medicine(s) wherever/whenever necessary.
2. I accept responsibility for advising you immediately of any change of treatment prescribed by any doctor/hospital.
3. I understand and accept that the school administers the medication voluntarily at my request.

Signed: _____ (Parent/Carer) Name: _____ Date: _____

Confirmation of the School's Agreement

I agree that (pupil's name) _____ may receive the medication detailed on this form at the specific times also detailed. Unless parental advice and consent has been given otherwise (pupil's name) _____ will be given the medication by an authorised member of staff.

This agreement will continue either until the end of the course of medication or until we are instructed by parents in writing.

The school may review these arrangements any time subject to suitable notice being given.

Signed (member of SLT): _____ Name: _____ Date: _____