Parental Agreement for Medication Administration

	Parental Agreement for Medication Administration
	The school/setting will not give your child medicine unless you complete and sign this form, in line with Sherborne Area Schools' Trust policy.

Date					
Name of school/setting *Please provide full name here. SPS could stand for several schools in our trust. Please do not abbreviate.*	King Arthur's School				
Name of child *Please ensure child's full name (including middle names) is detailed here. There could be several 'M Smith's' in the schools. Please do not abbreviate.*					
Date of birth					*Please ensure these details are clear and the numbers cannot be confused*
Group/class/form					
Medical condition or illness *Please give as much information here as you possibly can. This will help those administering medication to have a greater knowledge of a child's condition.*					
Medicine					
Name/type of medicine *(as described on the container)*					
Expiry date					*Please detail as per container. And give full year of expiry.*
Dosage and method *Please ensure you are detailing dosage and method exactly as described on the container. A good example of this would be 'Take one tablet three times a day' A poor example would be '1 x 3 x a day'.*					
Timing *Full sentences are required here at all times - A good example here would be 'Twenty minutes before meals'*					

Special precautions/other instructions *Information should be written exactly as detailed on the container*	
Are there any side effects that the school/setting needs to know about? *Ensure full detailed information is given here*	
Self-administration – y/n	
Procedures to take in an emergency *It is vital full details are given here. 'Contact SV and ring 999' is not a detailed explanation.*	
NB: Medicines must be in the original container as dispensed by the pharmacy **Contact Details (Parent / Guardian)**	
Name	
Daytime telephone no.	
Relationship to child	
Address	

I understand that I must deliver the medicine personally to ….	(agreed member(s) of staff / school office)

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

Signature(s)_____ Date_____

Record of Medicine Administered to an individual child

	Record of medicine administered
	The school/setting will retain this record in accordance with SAST Policy

Name of school/setting	King Arthur's School
Name of child	
Date medicine provided by parent	
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	
Quantity returned	
Dose and frequency of medicine	

Staff signature _____

Signature of parent _____

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			
Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Record of Medicine Administered to an individual child (continued)

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			