Add the name and address of the school/nursery here

Add the name of head teacher/senior nursery staff member here

**Appendix C:** **Parental/guardian consent to administer a non-prescription (over-the-counter) medicine**

* All non-prescription (over the counter) medicines must be in the original container.
* A separate form is required for **each medicine**.

|  |  |
| --- | --- |
| **Child’s name** |  |
| **Child’s date of birth** |  |
| **Class/form** |  |
| **Name of medicine** |  |
| **Strength of medicine** |  |
| **How much (dose) to be given. For example:** **One tablet****One 5ml spoonful** |  |
| **At what time(s) the medication should be given** |  |
| **Reason for medication** |  |
| **Duration of medicine**Please specify how long your child needs to take the medication for |  |
| Are there any possible side effects that the school needs to know about? If yes, please list them |  |

|  |  |  |
| --- | --- | --- |
| I give permission for my son/daughter to carry and administer their own medication in accordance with the agreement of the school and medical staff. | Yes |  |
| No |  |
| Not applicable |  |

|  |  |
| --- | --- |
| **Mobile number of parent/carer** |  |
| **Daytime landline for parent/carer** |  |
| **Alternative emergency contact name** |  |
| **Alternative emergency phone no.** |  |
| **Name of child’s GP practice** |  |
| **Phone no. of child’s GP practice** |  |

* I give my permission for the Head teacher/senior nursery staff member (or his/her nominee) to administer the OTC medicine to my son/daughter during the time he/she is at school/nursery. I will inform the school/nursery immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is no longer needed.
* I understand that it may be necessary for this medicine to be administered during educational visits and other out of school/nursery activities, as well as on the school/nursery premises.
* I confirm that the dose and frequency requested is in line with the manufacturers’ instructions on the medicine.
* I confirm that my son/daughter has previously taken the medication and has had no know adverse reactions to the medication.
* I also agree that I am responsible for collecting any unused or out of date medicines and returning them to the pharmacy for disposal. If the medicine is still required, it is my responsibility to obtain new stock for the school/nursery.
* The above information is, to the best of my knowledge, accurate at the time of writing.

|  |  |
| --- | --- |
| **Parent/carer name** |  |
| **Parent/carer signature** |  |
| **Date** |  |

Add the name and address of the school/nursery here

Add the name of head teacher/senior nursery staff member here

**Appendix D: Parental/carer consent to administer a prescribed medicine**

* All prescribed medicines must be in the original container as dispensed by the pharmacy, with the child’s name, the name of the medicine, the dose and the frequency of administration, the expiry date and the date of dispensing included on the pharmacy label.
* A separate form is required for **each medicine**.

|  |  |
| --- | --- |
| **Child’s name** |  |
| **Child’s date of birth** |  |
| **Class/form** |  |
| **Name of medicine** |  |
| **Strength of medicine** |  |
| **How much (dose) to be given. For example:** **One tablet****One 5ml spoonful** |  |
| **At what time(s) the medication should be given** |  |
| **Reason for medication** |  |
| **Duration of medicine**Please specify how long your child needs to take the medication for. |  |
| Are there any possible side effects that the school needs to know about? If yes, please list them |  |

|  |  |  |
| --- | --- | --- |
| I give permission for my son/daughter to carry their own salbutamol asthma inhaler/Adrenaline auto injector pen for anaphylaxis [delete as appropriate]. | Yes |  |
| No |  |
| Not applicable |  |

|  |  |  |
| --- | --- | --- |
| I give permission for my son/daughter to carry their own salbutamol asthma inhaler and use it themselves in accordance with the agreement of the school and medical staff. | 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 school and medical staff. | Yes |  |
| No |  |
| Not applicable |  |

|  |  |
| --- | --- |
| **Mobile number of parent/carer** |  |
| **Daytime landline for parent/carer** |  |
| **Alternative emergency contact name** |  |
| **Alternative emergency phone no.** |  |
| **Name of child’s GP practice** |  |
| **Phone no. of child’s GP practice** |  |

* I give my permission for the head teacher /senior nursery staff member (or his/her nominee) to administer the prescribed medicine to my son/daughter during the time he/she is at school/nursery. I will inform the school/nursery immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.
* I understand that it may be necessary for this medicine to be administered during educational visits and other out of school/nursery activities, as well as on the school/nursery premises.
* I confirm that the dose and frequency requested is in line with the manufacturers’ instructions on the medicine.
* I also agree that I am responsible for collecting any unused or out of date medicines and returning them to the pharmacy for disposal and supplying new stock to the school/nursery, if necessary.
* The above information is, to the best of my knowledge, accurate at the time of writing.

|  |  |
| --- | --- |
| **Parent/carer name** |  |
| **Parent/carer signature** |  |
| **Date** |  |

Add the name and address of the school/nursery here

Add the name of head teacher/senior nursery staff member here

**Appendix E: Record of Medicine Administered for an Individual Child**

|  |  |
| --- | --- |
| Name of school/setting |  |
| 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 |  |  |  |

**C: 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 |  |  |  |

|  |  |
| --- | --- |
| Name of school/setting |  |
| Name |  |
| Type of training received |  |
| Date of training completed |  |  |  |  |
| Training provided by |  |
| Profession and title |  |

Add the name and address of the school/nursery here

Add the name of head teacher/senior nursery staff member here

**Appendix F: Staff Training Record – Administration of Medicines**

I confirm that [name of member of staff] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [name of member of staff].

Trainer’s signature

Date

**I confirm that I have received the training detailed above.**

Staff signature

Date

Suggested review date