



# Ellington Primary School



## Administration of Medication to Pupil

### Agreement between Parents and School

A parent must supply a written request in order for medication to be administered to pupils during school hours. It is only possible to administer medication that the child's doctor has prescribed. School staff cannot administer 'over-the-counter' medication.

It is also important to keep the administration of medication to a minimum and parents are requested to consider the possibility of administering the daily doses out of school hours. If this is not possible the following consent form must be completed and returned to the school:

**Note: Medicines must be kept in the original container as dispensed by the pharmacy.**

### Part 1 – To be Completed by Parent/Carer

To the Headteacher:

Mr Kevin Hodgson

School:

Ellington Primary School

My child (*name*) \_\_\_\_\_ Date of birth: \_\_\_\_\_

Class \_\_\_\_\_ has the following medical condition \_\_\_\_\_

I wish for him/her to have the following medicine administered by school staff, as indicated below:

Name of Medication:

Dose/Amount to be given:

Time(s) at which to be given:

Means of administration:

How long will the child require this medication to be administered?

Known side effects and any special precautions (please attach details)

Procedures to take in case of emergency (please attach details)



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## Part 1 continued – To be Completed by Parent/Carer

### Emergency Contact 1

Name: \_\_\_\_\_

Telephone \_\_\_\_\_

Work: \_\_\_\_\_

Home: \_\_\_\_\_

Mobile: \_\_\_\_\_

Relationship: \_\_\_\_\_

### Emergency Contact 2

Name: \_\_\_\_\_

Telephone \_\_\_\_\_

Work: \_\_\_\_\_

Home: \_\_\_\_\_

Mobile: \_\_\_\_\_

Relationship: \_\_\_\_\_

*I undertake to deliver the medicine personally to the Headteacher or Medication Coordinator and to replace it whenever necessary. I also undertake to inform the school immediately of any change of treatment that the doctor or hospital has prescribed.*

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Date: \_\_\_\_\_

## Part 2 - To be completed by Headteacher/Medication Coordinator

### Confirmation of agreement to administer medicine

It is agreed that (child) \_\_\_\_\_ will receive (quantity and name of medicine) \_\_\_\_\_ every day at (time medicine to be administered, for example, lunchtime or afternoon break) \_\_\_\_\_.

(Child) \_\_\_\_\_ will be given medication or supervised whilst he/she takes it by (name of member of staff) \_\_\_\_\_.

This arrangement will continue until \_\_\_\_\_ (either the end date for the course of medicine or until the parents instruct otherwise).

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Signed (Headteacher/Medication Coordinator) \_\_\_\_\_