Medical Information

The school will not give your child medicine unless you complete and sign this form and the Headteacher has agreed that school staff can administer the medication.

Name: _____ **Photo**:

Date of Birth: _____

Address: _____

_____

_____ **Date**: _____ **M / F**

Year group/Class: _____ **Review date**: _____

Condition: _____

_____

Contact Information

Family Contact 1

Name: _____ **Relationship:** _____

Work telephone: _____ **Home telephone:** _____

Family Contact 2

Name: _____ **Relationship:** _____

Work telephone: _____ **Home telephone:** _____

Clinic/Hospital contact

Name: _____ **Telephone:** _____

General Practitioner

Name: _____ **Telephone:** _____

Medication

Name/Type of Medication (as described on the container): _____

_____

For how long will your child take this medication: _____

Date dispensed: _____

Expiry Date: _____

Full directions for use

Dosage and method: _____**Timing:** _____

Special precautions: _____

_____

Side effects: _____

_____

_____

Self-Administration: Delete **Yes / No**

Describe what constitutes an emergency:_____

_____

_____

Procedures to take in an emergency: _____

_____

NB: Medicine must be in the original container as dispensed by the pharmacy.

Give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.

Daily care requirements

Specific support for the pupil's educational, social and emotional needs.

Arrangements for school visits/trips etc.

Other information.

Staff training needed/undertaken – who, what, when.

I understand that I must deliver the medicine personally to my child's classteacher and accept that this is a service which the school is not obliged to undertake. I am also responsible to monitor the expiry date of medication in school and provide new medication when necessary.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine 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 medicine is stopped.

Signature: _____ **Relationship to child:** _____

Date: _____

Signed by Headteacher_____

Form copied to: Parents SENCo Class teacher Medical File