**FENSTANTON & HILTON PRIMARY SCHOOL MEDICINES POLICY**

**PARENTAL / CARERS REQUEST FOR MEDICATION TO BE ADMINISTERED IN SCHOOL**

 **PLEASE READ. In accordance with our school medicines policy:-**

* The school will not administer any medication without this form being completed first.
* The school will only administer medication that is in the original container with the pharmacy label clearly showing the child’s name, medication name, dosage and expiry date.
* **The school will not administer medication that has been prescribed to be taken 3 times per day.**
* The school will administer medication that has been prescribed to be taken 4 times per day.
* **The school will administer medication at lunchtime only – guaranteed timings cannot be assured** (Excluding medication for ongoing conditions eg Asthma, Diabetes, Anaphylaxis)
* **Parents/Carers may come into school to administer medication.**
* The request form for pupils on long term medication should be renewed by the parent/carer when required by school and in any event at the beginning of each new school year.
* Parents/Carers are responsible for notifying the school immediately in writing of any changes in medicines or dosage.
* Parents/Carers are responsible for collecting and disposing of any unused or expired medicine.

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| --- | --- |
| CHILD’S NAME | CHILD’S CLASS |
| DATE OF BIRTH | MALE/FEMALE | ADDRESS |
| CONDITION /ILLNESS |
| DOCTOR’S NAME | DOCTOR’S PRACTICE | PRACTICE ADDRESS |
| NAME OF MEDICATION | TYPE OF MEDICATION: SYRUP / TABLET / INHALER /EPIPEN / OTHER, PLEASE SPECIFY: |
| DATE DISPENSED | DOSAGE AND METHOD | BEFORE / AFTER LUNCH |
| PRECAUTIONS/ SIDE EFFECTS | TO BE ADMINISTERED BY CHILD?YES / NO | EMERGENCY PROCEDURE |
| TO BE COLLECTED AT THE END OF EACH DAY YES/NO IF YES,WHO WILL COLLECT |
| PARENT/CARER’S NAME | RELATIONSHIP TO CHILD | CONTACT PHONE NO. | ADDRESS. AS ABOVE /OR: |

**I UNDERSTAND THAT I MUST DELIVER THE MEDICATION TO THE SCHOOL OFFICE AND COLLECT IT WHEN FINISHED AND ACCEPT THAT THIS IS A SERVICE WHICH THE SCHOOL IS NOT OBLIGED TO UNDERTAKE.**

 **I AUTHORISE THE QUALIFIED FIRST AIDERS TO ADMINISTER THE ABOVE MEDICATION AND RELEASE THEM FROM ALL FURTHER LIABILITY FOR ANY CONSEQUENT ADVERSE EFFECTS, REACTIONS OR ANY UNFORESEEN CIRCUMSTANCES WHICH MIGHT ARISE.**

**I HAVE READ THE STATEMENT ABOVE AND POLICY DETAILS AT THE TOP OF THE PAGE.**

**SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**