PARENTAL AGREEMENT FOR A DCC ESTABLISHMENT TO ADMINISTER MEDICINE

DCC Establishment / Setting .....

Notes to Parent / Guardians

Note 1: *This establishment will only give your child medicine when you have completed and signed this form and where there is a school policy that staff can administer medicine.*

Note 2: *All medicines must be in the original container as dispensed by the pharmacy, with the young person's name, its contents, the dosage and the prescribing doctor's name.*

Note 3: *The information is requested, in confidence, to ensure that the establishment is fully aware of the medical needs of your child. While no staff member can be compelled to give medical treatment to a young person, it is hoped that the support given through parental consent, the support of the County Council through these guidelines and the help of the School Medical Service will encourage them to see this as part of the pastoral role. Where such arrangements fail it is the parents' responsibility to make appropriate alternative arrangements*

Prescribed Medication

Date	
Child's name	
Date of birth	
Group/class/form	
Name and strength of medicine	
How much to give (i.e. dose to be given)	
When to be given	
Reason for medication	
Number of tablets/quantity to be given to the establishment	
Time limit – please specify how long your child needs to be taking the medication	_____day/s _____week/s
I give permission for my son/daughter to carry their own asthma inhalers	Yes / No / Not applicable
I give permission for my son/daughter to carry their own asthma inhaler and managed its use	Yes / No / Not applicable

I give permission for my teenage son/daughter to carry their adrenaline auto injector for anaphylaxis (epi pen)	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 establishment and medical staff	Yes / No / Not applicable

Daytime phone number of parent or adult contact	
Alternative Contact in the event of an emergency	
Name and phone number of GP	
Agreed review date to be initiated by (named member of staff)	

I confirm that the medicine detailed overleaf has been prescribed by a doctor, and that I give my permission for the Head Teacher (or his/her nominee) to administer the medicine to my son/daughter during the time he/she is at Copplestone Primary School.

I will inform the establishment immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I also agree that I am responsible for collecting any unused or out of date supplies and that I will dispose of the supplies.

The above information is, to the best of my knowledge, accurate at the time of writing.

Parent's Signature Date ..... Date .....
(Parent/Guardian/Person with parental responsibility)