DUNHOLME ST CHAD'S CE PRIMARY SCHOOL Parental request for school to supervise self-administration of medication

The school will not supervise self-administration of medicines by a pupil unless you complete and sign this form and the Headteacher has given his/her authorisation.

DETAILS OF PUPIL Full Name	
Class	Date of Birth
Address	
Condition or illness	
CONTACT DETAILS:	
Name:	Relationship to Pupil
Daytime Tel Nos	
Medical Practice	
MEDICATION – As appropriate medication must be in	n its original container, or a container suitable for a
single dose, and clearly marked with the name of child	d. Parents/guardians are responsible for ensuring
medication is in date and all necessary equipment is s	supplied. Out of date medication should be removed
from school.	
Name/Type of Medication (as described on container)	l
For how long will your child take this medication (plea	se delete as appropriate) Short Term / Ongoing
Full Directions for use:	
Dosage and method	
Timing:	
Special Precautions:	Side Effects:
Procedures to take in an Emergency	
Storage arrangements for medication (Office/classroo	
I understand that I must deliver the medicine personal	lly to the Head Teacher or the school office as
previously agreed and accept that this is a service wh	ich the school is not obliged to undertake.
Signed (parent/guardian)	Authorised Headteacher/Senior teacher
Name	
Date	Date

PTO for record of administration

Record of Observation Administration of Medicine

Medication (delete as appropriate)

- Inhalers (Children use inhalers on an as and when basis and no formal record of use is kept).
- Brought in daily eg short term antibiotics
- Long term daily administration
- Other

Please use the chart below to record the observation of self administration of
medicine (as detailed overleaf):
Name of child

Date	Quantity of	Amount of	Time	Initials of person
	medication	medicine	administered	observing
	received	taken		