**Lowton West Primary School**

**Essential Medication**

Occasionally prescribed medicines need to be taken during the school day. Ideally this should be done by a parent/carer coming into school to administer it, but we appreciate that this may sometimes be difficult due to work commitments. If you are unable to come in to school to administer the medication, please complete the form below. **The school cannot allow any medication in school unless this form is completed, signed and returned.**

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| --- |
| **Pupil Details** |
| Name: | Class: |
| Address: | Date of Birth:  |
| Condition/Illness  |

|  |
| --- |
| **Medication** |
| Name & Type of Medication: | How long will your child require this medication for? |
| Dosage Method (include dosage and times): | Side Effects: |

|  |
| --- |
| **Contact Details of Parent/Carer** |
| Name: | Daytime Telephone No: |
| Relationship to Child: | Address: |

**I understand that an adult must deliver and collect the medicine to and from a member of staff and I accept that this is a service which school is not obliged to undertake.**

**Signed:**

(Parent/ Carer)

**Date:**

**FORM 3B**

Parental agreement for school to administer medicine.

Lowton West Primary school will not give your child medicine unless you complete and sing this form. The school has a policy that staff can administer medicine.

(Policy on Medicines in School available on the school website.)

|  |  |
| --- | --- |
| Name of School: | Lowton West Primary School |
| Date: |  |
| Child’s Name: |  |
| Class: |  |
| Name and strength of medicine  |  |
| Expiry Date: |  |
| How much to give (i.e. dose to be given) |  |
| When to be given: |  |
| Any other instructions: |  |
| Number of tablets/ quantity to be given to school:**Note: Medicines must be the original container as dispensed by the pharmacy** |  |
| Daytime telephone number of parent/ carer: |  |
| Name and telephone number of GP: |  |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent for the staff at Lowton West Primary to administer medicine in accordance with the school policy. I will inform school immediately in writing if there is any dosage or frequency of the medication or if the medicine is stopped.

**Parent signature:**

**Print name:**

Agreed review date to be initiated by (Member of staff):