Appendix ‘D’

Record of Medicine Administered to an Individual Child

|  |  |  |
| --- | --- | --- |
| Pupil Name: | | Medical condition / Illness: |
| Date of Birth: | Class: | Any allergies to medication: |

**Medication Information**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of medicine  (as described on the container) |  | | | | | | | | |
| Date Dispensed |  |  |  |  |  |  |  |  |  |
| Expiry date |  |  |  |  |  |  |  |  |  |
| Dosage and method |  |  |  |  |  |  |  |  |  |
| How medicine is taken |  |  |  |  |  |  |  |  |  |
| Timing / when to be given |  |  |  |  |  |  |  |  |  |
| Duration of course |  |  |  |  |  |  |  |  |  |
| Special precautions |  |  |  |  |  |  |  |  |  |
| Any known side effects |  |  |  |  |  |  |  |  |  |
| Has the medication been administered before? |  |  |  |  |  |  |  |  |  |

**Contact Information**

|  |  |
| --- | --- |
| Parent /Carer name & number | 1 |
|  | 2 |
| Emergency contact name & number | 1 |
|  | 2 |
| GP name / number |  |

**Agreement**

* I understand that the medicine must be delivered to school either by me personally or by responsible named adult (adult-adult handover).
* This medicine must have been prescribed by doctor, dentist, nurse prescriber or pharmacist prescriber.
* I agree to inform the school of any changes in dose of medication as instructed by the doctor / termination of medication immediately.
* I accept that only medication prescribed for 4 times a day will be given in school (except in specially agreed circumstances.
* The medication must be provided to school in its original packaging with pharmacy label stating contents, dosage, expiry date/dispensing date and the child’s name in full.
* I accept that this is a service that the school is not obliged to undertake.

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

Parent / carer signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_