KILMORIE
PRIMARY SCHOOL

The school will not give your child medicine unless you complete and sign this form, and the head teacher or deputy head has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Surname:_____

Forename(s)_____

Address_____

_____

Male/Female: _____

Date of Birth: _____

Class: _____

MEDICATION

Reason for medication :_____

Name/Type of medication (as described on the container)_____

For how long will you child take this medication:_____

Date dispensed:_____

FULL DIRECTION OF USE

If medication given at home this morning, at what time: _____

Dosage and method:_____

Timing(s)_____

Special Precautions:_____

Side Effects:_____

Self Administration:_____

Procedures to take in an emergency_____

Any other information necessary :

CONTACT DETAILS

Name: _____ Daytime Telephone No:_____

Relationship to pupil:_____

Address:_____

I understand that I must deliver the medicine personally to (agreed member of staff) and accept that this is a service which the school is not obliged to undertake. I will ensure that I collect the medication at the end of the prescribed time

Date:_____

Signature:_____ Relationship to child:_____

WRAP AROUND CARE

My child attends Kilmorie Wrap Around Care provision and needs to have their medication whilst in their care. I understand that the designated member of the school staff will deliver the medication to the Wrap Around Care Manager, who will oversee administration and return to the office. I accept that this is a service which the school is not obliged to undertake.

Date:_____

Signature:_____ Relationship to child:_____

For School Use Only

Agreed by HT/DH (date) ……..

The following staff have agreed to administer

Michaela Toppar, Louise Hopper,

Collected from parent on ……. Signed …….

Collected by Parent on …….. Signed …….