

PARENTAL AGREEMENT FOR HEATHERWOOD SCHOOL STAFF TO ADMINISTER MEDICINE (including personal care items)

Heatherwood staff cannot not give your child medication unless you complete and sign this form.



Pupil Name: _____ Date of Birth: _____ Class: _____

Name/type of medicine (as described on the container including strength)	Dosage	Route	Enteral medication Pre and Post flush amounts	Time of administration	Any administration instructions	Side effects that school needs to know about?	Self-administration – y/n
Medication 1							
Medication 2							
Medication 3							
Medication 4							
Medication 5							
Medication 6							
Medication 7							
Medication 8							
NB: Medicines must be in the original container as dispensed by the pharmacy				No opened medication will be accepted into school.			
Expiry date must be clearly labelled				Prescription labels must be CLEAR and include child's name.			

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

I will inform Heatherwood, in writing, when sending in medication, if there are any changes in dosage, frequency or if the medicine is stopped.

Signed: _____ Name: _____ Date: _____ School Representative

Signed: _____ Name: _____ Date: _____ Parent/Carer

Where possible we encourage medication to be administered outside of school hours. However, if there are four doses per day or if they are time specific school will gladly administer.

THIS FORM IS TO BE UPDATED EACH ACADEMIC YEAR OR WHEN CHANGES ARE NECESSARY