

**Cranborne Middle School**

**Authorisation for the Administration of Medicine by School Staff**

**ONLY TO BE COMPLETED IF MEDICATION IS TO BE STORED AT THE OFFICE**

**The school will not administer medication without receipt of this completed and signed form.**

**PUPIL DETAILS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Date of birth | | | | Tutor Group |
| Address | | | | | Medical Condition or illness |
| **MEDICATION**  **NB: Medicines must be prescribed by the doctor and be in the original container as dispensed by the pharmacy** | | | | | |
| Name/type of medicine*(as described on the container)* | | | | | |
| Name of Doctor prescribing medication: | | | | | |
| For how long will your child need to take this medication: | | | | | |
| Expiry date | | | | Date dispensed | |
| **NB: It is the responsibility of parent/carer to ensure medication has not exceeded expiry date.** | | | | | |
| **DIRECTIONS FOR USE**  Dosage and method of Administration | | | | | |
| Time of Administration | | | | Self-administration – y / n | |
| Special precautions/other instructions | |  | | | |
| Possible side effects | |  | | | |
| Procedures to take in an emergency | |  | | | |
| **ASTHMA INHALERS**   * **All inhalers should be clearly labelled with pupil’s name and tutor group** * Written permission on the appropriate form (available on request) required for pupil to carry inhaler on their person. * Additional inhaler to be kept in the school office. * Recommended dose   **CONTACT DETAILS** | | | | | |
| Name | | | Relationship to child | | |
| Address | | | Daytime telephone no. | | |  |

* 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 am aware that the school offer NO guarantee that medication will be administered at the stated time and that the responsibility of attending the school office to receive medication falls to the pupil.
* The pupil should collect medication from the school office at the end of the day.
* The school accepts NO responsibility for any adverse reaction to the medication described above.
* I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature…………………………………………………………………Parent/Carer Date………………………………………...

Please print name………………………………………………………..