APPENDIX ONE - **MEDICATION PERMISSION FORM**

In signing this form, parents give permission for the administration of prescribed medication as

detailed by a doctor for short-term illness and in an emergency for long-term illness.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Pupil’s name |  | | | | Year |  | |
| DETAILS OF MEDICINE PROVIDED | | | | | | | |
| Date | | |  | | | | |
| Name of medication | | |  | | | | |
| Dose | | |  | | | | |
| This course of medication lasts for | | |  | | | | |
| Reason for Medication or Medical Condition | | |  | | | | |
| Device/Equipment/Bottle Provided | | |  | | | | |
| Expiry Date of Medication | | |  | | | | |
| Signature of Parent | | |  | | | | |
| Signature of Staff Member/Headmistress | | |  | | | | |
| ADMINISTRATION OF MEDICATION | | | | | | | |
| Time/Date medication was administered | | |  | | | | |
| Dose | | |  | | | | |
| Name of staff administering medication | | |  | | | | |
| Signature of staff administering medication | | |  | | | | |
| Signature of witness | | |  | | | | |
| Medication stored correctly | | | Yes/No (Delete as appropriate) | | | | |
| RETURN OF MEDICATION | | | | | | | |
| Time/Date medication returned to parents | | |  | | | | |
| Signature of staff member | |  | | Signature of parent | | |  |

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| MEDICATION PERMISSION FORM |

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| RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL CHILD | | | | | | | |
| Pupil’s name | | |  | | Year | |  |
| DAY 2 | | | | | | | |
| Time of last dose | Dose to be administered | | | Time of next dose | | Parent signature | |
|  |  | | |  | |  | |
| Time medication was administered | Dose administered | | | Staff signature | | Witness signature | |
|  |  | | |  | |  | |
| Medication stored correctly Yes / No | | | | Time medication returned | |  | | |
| DAY 3 | | | | | | | |
| Time of last dose | Dose to be administered | | | Time of next dose | | Parent signature | |
|  |  | | |  | |  | |
| Time medication was administered | Dose administered | | | Staff signature | | Witness signature | |
|  |  | | |  | |  | |
| Medication stored correctly Yes / No | | | | Time medication returned | |  | | |
| DAY 4 | | | | | | | |
| Time of last dose | | Dose to be administered | | Time of next dose | | Parent signature | |
|  | |  | |  | |  | |
| Time medication was administered | | Dose administered | | Staff signature | | Witness signature | |
|  | |  | |  | |  | |
| Medication stored correctly Yes / No | | | | Time medication returned | |  | | |
| DAY 5 | | | | | | | |
| Time of last dose | | Dose to be administered | | Time of next dose | | Parent signature | |
|  | |  | |  | |  | |
| Time medication was administered | | Dose administered | | Staff signature | | Witness signature | |
|  | |  | |  | |  | |
| Medication stored correctly Yes / No | | | | Time medication returned | |  | | |

*Please attach additional sheets if medication is required for more than 5 school days.*