**St Laurence School**

**Parental/carer consent for students to self-administer Medication in the presence of staff**

*The School will not give your child the stored medicine unless you complete all sections and sign this form.* *Please note medication will not be administered prior 12:00, unless instructed by a pharmacy prescribed medication label. Or medical correspondence has been provided by GP or consultant.*

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| --- | --- | --- | --- |
| Childs Surname  |   | Childs Forename  |   |
| Date of Birth  |   | Tutor Group  |   |
| Reason for Medication  |   |
| **Name/Type of Medication** *(as described on the container)*  |   |
| **Duration of medicine**, please specify how long your child needs to take the medication for. Any long-term medication (e.g. paracetamol-the recommended instruction- usually 3 days needs to be supported with Medical Evidence from a Health professional). |   |
| **FULL DIRECTIONS FOR USE:**  |   |
| How much (dose)to be given, e.g. One tablet |  |
| Strength of medication: e.g. 500mg  |   |
| At what time(s) the medication should be given |  |
| Are there any possible side effects that school needs to know about? If yes, please list. |   |
| Can the child Self- Administrate  |   YES  No |
| Procedures to take in an Emergency:  |   |
| **HAS YOUR CHILD BEEN PRESCRIBED AN ADRENALINE AUTO INJECTOR?**  |   YES  No Details of AAI: |
| I give permission for my child to administer their own medication in accordance with the agreement of the school & medical staff |
| **CONTACT DETAILS**  |
| Parent/Carer Name  |
| Mobile number of parent/carer |   | Alternative emergency contact name |   |
| Childs GP and contact number |   | Alternative emergency contact number |   |

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| --- | --- | --- | --- |
| Date  |   | Parent/Carer Signature  |   |

* *I understand that I must deliver the medicine personally to the School Reception.*
* *I accept that this is a service which the school is not obliged to undertake.*
* *I confirm that the dose & frequency is in line with the manufacturers’ instructions on the medicine.*
* *I confirm my child has previously taken the medication and has no known adverse reaction to the medication.*
* *I agree I am responsible for collecting any unused or out of date medicines.*
* *The above information is, to the best of my knowledge, accurate at the time of writing.*

**For School Use**

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| --- | --- | --- | --- | --- | --- |
| **Date**  | **Time**  | **Medication**  | **Dose**  | **Reaction**  | **Signature**  |
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Revised 2023