**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 | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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* *I agree I am responsible for collecting any unused or out of date medicines.*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