# Frieth CEC School: parental agreement for school to administer medicine – page 1 of 2

The school will not give your child medicine unless you complete and sign this form.

|  |  |
| --- | --- |
| Date for review to be initiated by |  |
| Name of school/setting |  |
| Name of child |  |
| Date of birth |  |  |  |  |
| Group/class/form |  |
| Medical condition or illness |  |
| **Medicine** |  |
| Name/type of medicine*(as described on the container)* |  |
| Expiry date |  |  |  |  |
| Dosage and method |  |
| Timing |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school/setting needs to know about? |  |
| Self-administration – y/n |  |
| Procedures to take in an emergency |  |
| Prescription/Non-Prescription(Delete as appropriate) | Prescription | Non-prescription |
| **NB: Medicines must be in the original container as dispensed by the pharmacy****Contact Details** |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| I understand that I must deliver the medicine personally to | [agreed member of staff] |

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’s policy.

Prescribed Medication: 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. *(delete as appropriate)*

Non-prescription medication: I confirm that I have administered this non-prescription medication,without adverse effect, to my child in the past. I will inform the school immediately, in writing, if my child subsequently is adversely affected by the above medication. *(delete as appropriate)*

If more than one medicine is required a separate form should be completed for each one.

Signature(s) Date

# Frieth CEC School: request for child to carry his/her medicine – page 1 of 1

**THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN**

**If staff have any concerns they should discuss this request with school healthcare professionals**

|  |  |
| --- | --- |
| Name of School: |  |
| Child’s Name: |  |
| Group/Class/Form: |  |
| Address: |  |
|  |  |
| Name of Medicine: |  |
| Procedures to be taken in an emergency: |  |

**Contact Information**

|  |  |
| --- | --- |
| Name: |  |
| Daytime Phone No: |  |
| Relationship to child: |  |

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |

If more than one medicine is to be given a separate form should be completed for each one.

# Frieth CEC School: parent consent form – use of emergency salbutamol inhaler – page 1 of 1

………………………………………………………………. *(insert school name)*

**Child showing symptoms of asthma / having asthma attack**

1. I can confirm that my child has been diagnosed with asthma / has been prescribed an inhaler *(delete as appropriate)*.

2. My child has a working, in-date inhaler, clearly labelled with their name, which they will bring with them to school every day.

3. In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.

Signed: ……………………………………………………………….Date: ………………..

Name (print)……………………………………………………………………………………

Child’s name: .………………………………………………………………………………...

Class: ………………………………………………………………………………………….

Parent’s address and contact details:

…………………………………………………………………………………………………

.…………………………………………………………………………………………………

………………………………………………………………………………………………….

Telephone: ……………………………………………………………………………………

E-mail: …………………………………………………………………………………………

# Frieth C.E.C School: Individual Healthcare Plan – page 1 of 3

Insert Pupil’s Photo

|  |  |
| --- | --- |
| Name of school/setting | Frieth C.E.C School |
| Child’s name |  |
| Group/class/form |  |
| Date of birth |  |  |  |  |
| Child’s address |  |
| Medical diagnosis or condition |  |
| Date |  |  |  |  |
| Review date |  |  |  |  |
| **Family Contact Information** |  |
| Name |  |
| Phone no. (work) |  |
| (home) |  |
| (mobile) |  |
| Name |  |
| Relationship to child |  |
| Phone no. (work) |  |
| (home) |  |
| (mobile) |  |
| **Clinic/Hospital Contact** |  |
| Name |  |
| Phone no. |  |
| **G.P.** |  |
| Name |  |
| Phone no. |  |

|  |  |
| --- | --- |
| Who is responsible for providing support in school |  |

Page 2

Describe medical needs and give details of child’s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

|  |
| --- |
|  |

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

|  |
| --- |
|  |

Daily care requirements

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

Specific support for the pupil’s educational, social and emotional needs

|  |
| --- |
|  |

Page 3

Arrangements for school visits/trips etc

|  |
| --- |
|  |

Other information

|  |
| --- |
|  |

Describe what constitutes an emergency, and the action to take if this occurs

|  |
| --- |
|  |

Who is responsible in an emergency *(state if different for off-site activities)*

|  |
| --- |
|  |

Plan developed with

|  |
| --- |
|  |

Staff training needed/undertaken – who, what, when

|  |
| --- |
|  |

Form copied to

|  |
| --- |
|  |

Signed by: ……………………………………………………………………………………..

Job Title: ………………………………………………………………………………………

Signed by: ……………………………………………………………………………………..

Name of Parent: ………………………………………………………………………………

Date: …………………………………………………………………………………………...