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Appendix A (Medications Policy) – General Care Plan for short-term administration of medicines

General Care Plan/ Parent/Guardian/Carer CONSENT FORM

To: Headteacher of Mountfields Lodge Primary School (Academy)

From: Parent/Guardian of:			**(Full Name of Child)**
Class:		**Date of Birth:**	
My child has been diagnosed as having:			**(Name of condition/ailment)**
He/She has been considered fit for school but requires the following prescribed medicine to be administered during school hours:			**(Name of medication)**

Administration of Medication:

I **consent** for my child to carry out self-administration	(tick)
Date medicine provided by parent:	(DD/MM/YY)
Quantity received:	(e.g. ml, number of tablets)
Name of medicine:	
Strength of medicine:	
Expiry date:	(DD/MM/YY)
Dose and frequency of medicine:	
With effect from:	
Until:	
Method of administration:	(e.g. mouth, in ear, nasally)
Quantity returned:	(e.g. ml, number of tablets)

I **do not consent** for my child to carry out self-administration Please administer the medication as indicated below.	(tick)
Date medicine provided by parent:	(DD/MM/YY)
Quantity received:	(e.g. ml, number of tablets)
Name of medicine:	
Strength of medicine:	
Expiry date:	(DD/MM/YY)
Dose and frequency of medicine:	
With effect from:	
Until:	
Method of administration:	(e.g. mouth, in ear, nasally)
Quantity returned:	(e.g. ml, number of tablets)

I undertake to update the school with any changes in medication routine use or dosage.

I undertake to maintain an in date supply of the prescribed medication.

I understand that inhalers will be kept in a basket in my child's classroom but when my child is outside for PE or on an off-site visit etc the medication will be taken by an adult to accompany my child, or will be stored safely (as applicable).

I understand that the school cannot undertake to monitor the use of self administered medication and that the school is not responsible for any loss of/or damage to any such medication.

I understand that staff will be acting in the best interests of _____(Childs Name) whilst administering medication.

Signed:		**Date:**	
Name of parent (please print):			

Telephone Contact Details	
Home:	
Work:	
Mobile:	

Headteacher: Michael Hoare
or Health Care/Social Care Professional:

Record of medicine administered to _________________________________ (insert child's name)

Date									
Time given									
Dose given									
Name of member of staff									
Staff initials									

Date									
Time given									
Dose given									
Name of member of staff									
Staff initials									

Date									
Time given									
Dose given									
Name of member of staff									
Staff initials									

Date									
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