**PARENTAL AGREEMENT FOR A DCC ESTABLISHMENT TO ADMINISTER MEDICINE**

**Stoke Hill Federation**

***Notes to Parent / Guardians***

***Note 1:*** *This establishment will not give your child medicine unless you complete and sign this form and where the establishment has a policy that staff can administer medicine.*

***Note 2:*** *All Medicines must be in the original container as dispensed by the pharmacy, with the young persons name, its contents, the dosage and the prescribing doctor’s name*

***Note 3:*** *The information is requested, in confidence, to ensure that the establishment is fully aware of the medical needs of your child. While no staff member can be compelled to give medical treatment to a young person, it is hoped that the support given through parental consent, the support of the County Council through these guidelines and the help of the School Medical Service will encourage them to see this as part of the pastoral role. Where such arrangements fail it is the parents’ responsibility to make appropriate alternative arrangements*

**1. Prescribed Medication**

| Date |  |
| --- | --- |
| Child’s name |  |
| Date of birth |  |
| Group/class/form |  |
| Name and strength of medicine |  |
| How much to give (i.e. dose to be given) |  |
| When to be given |  |
| Reason for medication |  |
| Number of tablets/quantity to be given to the establishment |  |
| Time limit – please specify how long your child needs to be taking the medication | \_\_\_\_\_\_\_\_\_day/s \_\_\_\_\_\_\_\_week/s |
| I give permission for my son/daughter to carry their own asthma inhalers | Yes / No / Not applicable |
| I give permission for my son/daughter to carry their own asthma inhaler and managed its use | Yes / No / Not applicable |
| I give permission for my teenage son/daughter to carry their adrenaline auto injector for anaphylaxis (epi pen | Yes / No / Not applicable |
| I give permission for my son/daughter to carry and administer their own medication in accordance with the agreement of the establishment and medical staff | Yes / No / Not applicable |

| Daytime phone number of parent or adult contact |  |
| --- | --- |
| Alternative Contact in the event of an emergency |  |
| Name and phone number of GP |  |
| Agreed review date to be initiated by (named member of staff) |  |

I confirm that the medicine detailed overleaf has been prescribed by a doctor, and that I give my permission for the Head Teacher (or his/her nominee) to administer the medicine to my son/daughter during the time he/she is at a DCC establishment. I will inform the establishment immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. I also agree that I am responsible for collecting any unused or out of date supplies and that I will dispose of the supplies.

The above information is, to the best of my knowledge, accurate at the time of writing.

Parent’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian/Person with parental responsibility)