**Form 3A**

**PARENTAL AGREEMENT FOR THE ALDERMAN WHITE SCHOOL TO ADMINISTER MEDICINES**

The Alderman White School & Language College will not administer medicines to your child unless you complete and sign this form:

Name of Student: -------------------------------------------------------------------------------------------------------

Date of Birth: ----------------------------------

Form: ---------------------------------

Medical condition/illness: ---------------------------------------------------------------------------------------------

**MEDICINE**

Name/type of medicine: -------------------------------------------------------------------------------------------

(As described on the container)

Date dispensed: ---------------------------------------------------------------------------------------------------------

Expiry date: --------------------------------

Dosage & method: ------------------------------------------------------------------------------------------------------

Timing/ frequency: ------------------------------------------------------------------------------------------------------

Special precautions: -----------------------------------------------------------------------------------------------------

Side effects: ---------------------------------------------------------------------------------------------------------------

Self-administration: YES /NO (delete as appropriate)

Procedures to take in an emergency: ------------------------------------------------------------------------------

**CONTACT DETAILS**

Name: ---------------------------------------------------------------------------------------------------------------------

Daytime telephone number: ----------------------------------------------------------------------------------------

Relationship to student: ----------------------------------------------------------------------------------------------

Address: ------------------------------------------------------------------------------------------------------------------

***I understand that the medicines must be held in The Base***

***I accept that this is a service that the school is not obliged to undertake***

***I understand that I must notify the school of any change in writing***

Signature: --------------------------------------------------- Date: ------------------------------

**Form 5**

**Record of medicine administered to an individual student attending Alderman White School**

Name of Student: --------------------------------------------------------------------------------------------------------------

Form: -------------------------------------------------

Date medicine provided by parent: ---------------------------------------------------------------------------------------

Quantity received: -------------------------------------------------------

Name and strength of medicine: --------------------------------------------------------------------------------------------

Dose and frequency of medicine: -------------------------------------------------------------------------------------------

Expiry date: --------------------------------------------

Quantity returned: ----------------------------------

**Daily record**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date |  |  |  |  |  |
| Time Given |  |  |  |  |  |
| Dose Given |  |  |  |  |  |
| Staff Signature |  |  |  |  |  |
| Staff Initials |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date |  |  |  |  |  |
| Time Given |  |  |  |  |  |
| Dose Given |  |  |  |  |  |
| Staff Signature |  |  |  |  |  |
| Staff Initials |  |  |  |  |  |

**Form 7**

**Request for student attending the Alderman White School to carry his/her own medication**

This form must be completed by parent/ Career

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

Name of student: -----------------------------------------------------------------------------------------------------------------------

Form: ----------------------------------------

Name of medicine: ----------------------------------------------------------------------------------------------------------------------

Procedures to be taken in an emergency:------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**If students have more than one medicine to be administered a separate form should be completed for each one**

**Contact Information:**

**Priority Contact 1**

Name: -----------------------------------------------------------------------------------------------------------------------------

Daytime telephone number: -------------------------------------------------------------------------------------------------

Relationship to student: -------------------------------------------------------------------------------------------------------

**Priority Contact 2**

Name: ------------------------------------------------------------------------------------------------------------------------------

Daytime telephone number: -------------------------------------------------------------------------------------------------

Relationship to student: -------------------------------------------------------------------------------------------------------

Signature: ---------------------------------------------------- Date: -----------------------------------------------------------