Parental Agreement to Administer Medicine

Castle Hill Primary School will not administer medicine to your child unless you complete and sign this form in line with the Supporting Pupils with Medical Conditions and Allergy Policy.
Once completed please return to the school office.

N.B Medicines must be in the original container as dispensed by the Pharmacy. Without the original container we cannot administer the medicine.			
Name of School	**Castle Hill Primary School**		
Name of Child			
Date of Birth			
Year Group/ Class			
Medical Condition/ Illnesses			
Medicine Type(s) *(please list all medicine that will need to be administered in school)*			
Name of Medicine(s)			
Expiry Date of			
Expiry Date of			
Expiry Date of			
Dosage and Method			
Time to Administer Medicine(s)			
Course finish date:			
Special Precautions/ Other Instructions			
Are there any side effects that the school need to know about?			
Self-Administered? Yes/ No			
Procedure to take in an emergency			

CASTLE HILL PRIMARY SCHOOL

Parental Agreement to Administer Medicine

Parental Consent	
Name of Carer/ Parent	
Daytime Telephone Number	
Relationship to Pupil	
Home Address	
The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering medicine in accordance with the Supporting Pupils with Medical Conditions Policy. 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.	
Carer/ Parent Signature	
Dated	

School Emergency Inhaler and Parental Consent *(if applicable)*	
• I can confirm that my child has a prescribed reliever inhaler and a signed and dated Asthma Plan from the doctors, which has been provided to school. • My child has a working, in date inhaler, clearly labelled and has been advised to keep it with them at all times. • **In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my son/daughter to receive Salbutamol from an emergency inhaler held by the school.**	
Name of Carer/ Parent **Relationship to Pupil**	
Carer/ Parent Signature	
Dated	

School Adrenaline Auto-Injectors (AAI) and Parental Consent *(if applicable)*		
• I can confirm that my child has been diagnosed with an allergy and has a prescribed AAI and a signed and dated Allergy Action Plan from the hospital, which has been provided to school • My child has a working, in date **EpiPen/Jext** ***(delete as appropriate)***, clearly labelled and has been advised to keep it with them at all times. **In the event of my child displaying symptoms of anaphylaxis shock, and if their AAI is not available or is unusable, I consent for my son/daughter to receive a shot from an emergency EpiPen/Jext** ***(delete as appropriate)*** **in school. This will be the same brand of their own AAI.**		
Name of Carer/ Parent **Relationship to Pupil**		
Carer/ Parent Signature	**0.15mg**	**0.30mg**
Dated		

School Office Use ONLY

Item	Signature & Date
All Medicine above received in school ***(with prescribed label in original packaging)***	
Medicine Profile Spreadsheet updated (O:Drive)	
Asthma Plan Received – doctor signed & dated	
Allergy Action Plan Received – doctor signed & dated	