All Saints' Catholic Voluntary Academy

Head Teacher: C Cuomo

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"We shall serve."

Mark 10:45 - *"For even the Son of Man came not to be served but to serve, and to give his life as a ransom for many."*

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Medication to be provided by parent/carer and clearly labelled as below

Student Details

Name:	DoB:	Tutor Group:	Year Group:
Address:			

Medication Details

Name of **Prescription** Medication:		Name of **Non-Prescription** Medication:	
Description of Illness:			
Does your child have a Health Care Plan (HCP) in place at school?		Yes ☐	No ☐
Dose:	Time/s of day to be given:	Method of Administration:	
By Who: (Student/Adult)			
Date to start medication:		Date to end medication:	
Any special precautions required?		Any possible side effects?	
Procedures to take in an Emergency:			

Parent/Carer/Guardian Responsibility for Administration of Medication

I confirm that I have requested the school to administer medication to my child as detailed on this form. I understand and agree that:

- I retain full responsibility for my child's health and the provision of medication.
- I must ensure that all medication supplied is clearly labelled, in its original packaging, within date, and accompanied by written instructions from a healthcare professional where required. I will personally label the packaging of non-prescribed medication including the name and tutor group of my child.
- I am responsible for informing the school of any changes to my child's condition or medication.
- I understand that while the school will take reasonable care in administering medication, staff do so on a voluntary basis and cannot accept liability for any adverse effects arising from the medication, provided they have followed the instructions given.
- I understand that with the administration of prescription issued controlled drugs one staff member administers medication and another member of staff witnesses this.
- I will collect any unused medication at the end of the agreed period and/or ensure it is replaced as necessary.

Cont'd

PLEASE SIGN BELOW (if this form is not signed, we cannot administer medication)

By signing below, I agree to the above conditions and consent to the school administering the medication as directed.

By signing below, I declare that I have read and understood the school Medical Policy that is available on the All Saints website - Medical-Policy-School-1.pdf

SIGNATURE:	Print Name:
Relationship to Student:	
Phone No:	Email:

If you wish to discuss matters in more detail, please contact a member of the School First Aid Team.

Office Use

Date received:	**Staff Name:**	**Review Date:**
Administration of medication Can the student self-medicate and keep the medication on them? Y/N Should staff assist administration? Y/N	**How should Medication be stored?** Refrigerate Y/N Unlocked storage Y/N Secure locked cupboard (Controlled drugs) Y/N	