Kildwick CE Primary School

INSTRUCTION AN	ND AUTHORISATIO	N FOR THE	ADMINIS	STRATION OF MEDICATION				
Pupil's name	nameDate of birth							
Authorisation								
the medication deta	by authorise the Headteacher or person authorised by the Headteacher to administer dication detailed below. Should any changes in the medication be prescribed I will notify adteacher immediately. Instand that the person who administers the medication will not be medically trained and is not part of their obligations under their contract of employment. In that I will be responsible for the provision of the medication in an appropriate her bearing a clear label showing: The name of the medication The name of the patient The dosage Specific directions for Administration The date of issue or the expiry date That the Headteacher and school staff will take such care as would a reasonable to parent, and I confirm that I will not hold the Governors, the school staff or the stration of this medication. The final date of the medication of the medication of this medication.							
	•			•				
	•	the provision	n of the me	edication in an appropriate				
 ✓ the name of the medication ✓ the name of the patient ✓ the dosage ✓ specific directions for 			medication ✓ the name of the dispensing pharmacist/doctor ✓ the date of issue or the expiry					
I understand that the Headteacher and school staff will take such care as would a reasonable prudent parent, and I confirm that I will not hold the Governors, the school staff or the Education Authority responsible for any loss, damage or injury resulting from the administration of this medication.								
Details of medication	stration of this medication. sof medication to be administered in school							
Name of medication	Type (e.g. tablet, inhaler etc)	Dose	Time	Possible side effects and action/precautions to be taken				
Signed (Parent/Guardian)								
Date								
This section to be a	completed only at the	end of trea	itment.					
Date treatment sto	pped							
Signed			(Parent/Gu	uardian)				

TO BE COMPLETED BY THE SCHOOL

<u>Details of medication received</u>

Name of medication	Amount/number	Date of issue or expiry date (indicate which)	Dispensing pharmacist/doctor	Signed	Date

Record of medication administered in school

Name/strength of medication		Dosage	Route of administration	Dispensing pharmacist/doctor	
Dose	Date	Time	Administered by	Witnessed by	