**EDWARD FEILD SCHOOL**

**SHORT TERM MEDICATION PLAN**

**Parental/Headteacher agreement for school to administer/supervise medication.**

Employees are not obliged to administer medicines to pupils unless this is written into their job description. They may volunteer to administer emergency or long/short term medication for which they have received recognised training and will have indemnity from the L.E.A. as long as the procedure has been adhered to. They may also volunteer to administer essential medication for which the appropriate paperwork has been completed and will have indemnity from the L.E.A. as long as the procedure has been adhered to.

**The school will not adminster/supervise medication for your child unless you complete and sign this form. The school may refer this request to the School Nurse for advice before agreeing to it.**

NAME OF CHILD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLASS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL CONDITION / ILLNESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Name/Type Quantity of Medicine (as described on the container): |  |
| Start Date: |  |
| End date (maximum 1 week): |  |
| Dosage and method:  (Please be precise ie 1 x 5ml at 12.30pm) |  |
| Special Precautions: |  |
| Are there are side effects that the school/setting needs to know about? |  |

I understand that **an adult** must deliver the medicine (daily dose unless otherwise agreed) personally to: **The School Office** and I accept that this a service that the school is not obliged to undertake.

|  |  |
| --- | --- |
| Date: |  |
| Signature(s): |  |
| Relationship to child: |  |

**CONFIRMATION OF THE HEAD’S AGREEMENT TO ADMINISTER MEDICINE**

The school will administer/supervise the medication at the time and in the quantity agreed. The child will be supervised/given the medication by a member of staff.

Date:\_\_\_\_\_\_\_\_\_\_\_\_Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on behalf of the Head Teacher

The school setting will make every effort to provide this service, should for any reason the school be unable to provide this service the school/setting will inform the named contact at once, so that alternative arrangements can be made by the parent/carer.

MEDICATION TIMETABLE FOR :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Name of Supervisor/ Administrator | Dosage | Date & Time |
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