**Appendix C:**

**Record of Administration of medication that is given on a permanent basis i.e. Asthma/Eczema**

**GLAZEBURY C.E. PRIMARY SCHOOL & Nursery - Asthma medical form**

**Request for school, after school club and breakfast club to administer Inhaler(s).**

Dear Head Teacher,

I request that my child …………………………………………………….. be given the following inhaler(s) whilst in School/ Afterschool club / Breakfast club.

I confirm my child is aware how to correctly administer their own inhaler

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of inhaler** | **Expiry date of inhaler** | **Date prescribed** | **Dose prescribed** | **Maximum daily dose** | **Time to be given** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

I agree that the following complies with the school Medical & First Aid Policy:

• The above medication has been prescribed by the doctor, dentist, nurse or pharmacist

• It is clearly labelled indicating contents, dosage and child’s name in full.

• Medication will only be given if it requires administrating four times a day.

• I agree to inform School, ASC and Breakfast club of any change in dose immediately.

Name of parent/guardian: …………………………………………..…………………

Signed:………………………………………………………………………………. Date: ……………………………………

Please note: Medication will not be accepted by the school unless this form is completed and signed by the parent or legal guardian of the child.

The Governors and Head Teacher reserve the right to withdraw this service.

The inhaler will be returned to you at the end of the academic year or during the year if expiry date is met.

Signature of parent to confirm receipt of inhaler Date of inhaler returned to parent

…………………………………………………………………………. ………………………………………………………

**Appendix D: Record of Administration of prescribed medication**

**GLAZEBURY C.E. PRIMARY SCHOOL- Medicine form.**

**Request for school, after school club and breakfast club to administer Medicine(s).**

(This includes lip balms, cough sweets, sun cream)

Dear Head Teacher,

I request that my child …………………………………. be given the following medicine(s) whilst in School / Afterschool club / Breakfast club.

I confirm my child has had this medicine administered at home. The last occurrence was on

Date ………………………………………………….. at ………………………………

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of medicine** | **Expiry date of medicine** | **Check** **Dispensing Pharmacy name and contact on bottle** | **Dose prescribed** | **Date prescribed** | **Time to be given /Frequency** | **Duration of course** |
|  |  |  |  |  |  |  |
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**Possible side effects** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Ensure information leaflet is with medicine which will detail warnings & side effects)

I agree that the following complies with the schools Medical & First Aid Policy:

* The above medication has been prescribed by the doctor, dentist, nurse or pharmacist
* It is clearly labelled indicating contents, dosage and child’s name in full.
* Medication will only be given if it requires administrating four times a day.
* I agree to inform school, ASC and Breakfast club of any change in dose immediately.
* Check the name & dosage on the bottle corresponds with the name on the box.

Does this medicine need to be stored in a Fridge? YES/NO

Does this medicine contain paracetamol? YES / NO

How many days has your child been taking this medicine (to date)? …………………………

Name of parent/guardian: ………………………………………………..

Signed:………………………………………………………. Date: ……………………………………

Please note: Medication will not be accepted by the school unless this form is completed and signed by the parent or legal guardian of the child.

The Governors and Head Teacher reserve the right to withdraw this service.

Pupil’s Name …………………………………………………………… Class ……………….

Inhaler / medicine name: …………………………………………………….

Staff administering medicine must always wash hands with soap and water not gel.

Disposable gloves must be worn when handling creams and ointments.

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Dosage | Time | Two Staff Signatures(must be obtained) |
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# **If a child refuses to take medication –**

# **Please record and the parent/carer must be verbally informed.**