Little Hill Primary School

Giving Children a Flying Start

General Care Plan / Instruction to Administer Medication

To: Head Teacher of Little Hill Primary School

From: Parent / Carer of _____ (full name of child)

Child's Date of Birth: _____ Class: _____

- My child has been diagnosed as having: _____ (name of condition)
- (S)he is considered fit for school but requires the following prescribed medicine to be administered during school hours: _____ (name of medication)
- I **allow / do not allow** for my child to carry out self-administration (delete as appropriate)
- Could you please therefore administer the medication specified above, as follows _____ (dosage) at _____ (time) with effect from _____ (date) until advised otherwise
- The medicine should be administered by mouth / in the ear / nasally / other (please specify) (delete as applicable)

  _____

  I allow / do not allow for my child to carry the medication upon themselves (delete as appropriate)
- I will ensure that all medication supplied to the school is in a secure, labelled container as originally dispensed and is not a **non-prescribed medicine containing aspirin**.
- I will notify the school of any changes in routine, use or dosage.
- I agree to maintain an in date supply of the prescribed medication.
- I understand that the school cannot monitor the use of self-administered medication (Inhalers) carried by the child and that the school is not responsible for any loss of or damage to any medication.
- I understand that if I do not allow my child to carry the medication it will be stored by the school and administered by staff, with the exception of emergency medication which will be near my child at all times.
- I understand that staff will be acting voluntarily and in the best interests of my child whilst administering medicines to children.
- **I undertake to collect all medicines from the school when they are no longer required, expired and at the end of each term**.

Signed: _____ Date: _____

Name of parent / carer (please print) _____

Contact details:

Home _____ Work _____ Mobile _____

Record of Medicine Administration

Name of Child: .... Class: ....

Date	Time	Administered by	Dose and Comments	Witnessed by