Little Hill Primary School

Giving Children a Flying Start

General Care Plan/Instruction to Administer Medication – School Trip

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 with 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 therefore, please administer the medication specified above, as follows:

  …… (dosage) at …… (time) with effect from ……/……/20…… to ……/……/20…..

- 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 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 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 at the end of the school trip.**

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