**INSTRUCTION AND AUTHORISATION FOR**

**ADMINISTRATION OF MEDICATION**

School: Hemingbrough CP School

Pupil's Name: ..........................................................

Date of Birth: .............................

**Authorisation**

I hereby authorise the Headteacher or person authorised by the Headteacher to administer the medication detailed below. Should any changes in the medication be prescribed I will notify the Headteacher immediately.

I understand that the person who administers the medication will not be medically trained and that it is not part of their obligations under their contract of employment.

I confirm that I will be responsible for the provision of the medication in an appropriate container bearing a clear label showing:

\* the name of the medication

\* the name of the patient

\* the dosage

\* specific directions for the administration

\* precautions relating to the medication storage requirements

\* the name of the dispensing pharmacist/doctor

\* the date of the issue and the expiry date

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 to be Administered in School**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Medication | Type (eg tablet, inhaler, etc) | Dose | Time | Possible side effects and Action/ Pre-cautions to be taken | Date treatment due to be completed |
|  |  |  |  |  |  |

Signed: .....................................................................Parent/Guardian

Date: .....................................................................