Haygrove School Permission to Administer Prescribed Medication

1. Student Information

Name: ……

Tutor Group: …… Date of Birth: ……../……../……..

Address:

……

……

Postcode: …… Male ☐ Female ☐

2. Medication Information

Please Note that ONLY medication received in the ORIGINAL packaging, and with the original pharmacy dispensing label (prescription) or labelled with student name and tutor group (over the counter) will be received and administered.

Date Medication Received: …….. / …….. / ……..

Name of Medication: ……

Reason for Medication: ……

Date Medication Started: …….. / …….. / …….. Date Medication to Finish: …….. / …….. / ……..

Dose and Method of Administration: ……

Time(s) of administration:

……

Any Side Effects? ……

Any Other Information:

……

……

3. Permission

I agree that the above medication will be handed to the Principal First Aider for storage in Reception. All medication will be sent in the original packaging with the original dispensing label attached and legible. Over the Counter Medicine should be clearly labelled with the Name and Tutor Group, and expiry date clearly visible. I agree that the above medication can be administered at school

Signed: …… Date: …….. / …….. / ……..

Parent/Guardian

Print Name: ……

Relationship to Student: ……

OFFICE USE ONLY

Student Name: Tutor Group:

Date Received: …….. / …….. / ……..

Scanned to Arbor: …….. / ……. / ……..

Received By: ……

Scanned by: ……..

Job Title: ……

Job Title: ……..

Medication Checked (dispensing label present and legible): ……

Expiry Date of Medication: …….. / …….. / ……..

Quantity of Medication Remaining: ……..

Medication Disposal: ……

Date Disposed Of: …….. / ……. / ……..