APPENDIX A

ABBEY CATHOLIC PRIMARY SCHOOL
PRESCRIBED MEDICINE FORM

Staff receiving the medication must check that it is prescribed, correct name on medication & that dosage is clear ___ (please tick to confirm)

(IF MORE THAN ONE MEDICINE IS TO BE GIVEN A SEPARATE FORM MUST BE COMPLETED FOR EACH)

DATE(S) MEDICATION TO BE ADMINISTERED : _____
(if more than one day please specify all dates)

CHILD'S NAME _____DOB: _____ CLASS _____

MEDICAL CONDITION/ILLNESS: _____

NAME OF MEDICINE _____

DATE DISPENSED : _____ EXPIRY DATE: _____

NUMBER OF TABLETS/QUANTITY GIVEN TO SCHOOL (ie 1 bottle) _____
NB: Medication must be in the original container, as dispensed by the Pharmacy, with clear instructions on how much to give.

MEDICINE TO BE STORED WHERE (ie Fridge/room temp) _____

HOW MUCH TO ADMINISTER (i.e. dose to be given to child)_____

WHEN TO BE ADMINISTERED/OR SELF ADMINISTRATION (if states give on empty stomach - stomach needs to be empty for an hour before or after medication) _____

ANY KNOWN ALLERGIES _____

ANY OTHER INSTRUCTIONS _____

NAME OF G.P_____TEL NO: _____

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering the medication in accordance with school and LA policy. I will inform the school immediately in writing if there is any change in dosage or frequency of the medicine or if the medication is stopped.

PARENT'S SIGNATURE _____ PRINT NAME _____

PARENT CONTACT TEL NO _____

FOR OFFICE USE ONLY

Time, Date & Dose of Medicine Given	Administered by (PRINT name)	Witnessed by (PRINT name)

RECORD FOR RECEIPT AND RETURN OF MEDICATION			
Date received In school	Name of Person who received it	Date Returned to Parent/Carer	Signature of Person who collects it.