THE VALLEY SCHOOL

SUPPORTING PUPILS WITH MEDICAL NEEDS

ADMINISTRATION OF MEDICATION

"Learn to Believe – Learn to Achieve"

"Different for Different"

We will support all pupils, on an individual basis, to have full access to all school activities, to make progress in their learning and in their overall development by recognising their medical needs, supporting them to access medical and therapeutic interventions and by modifying their provision as necessary

Please complete

Name of Student			
Tutor Group			
Medical condition or illness			
Delete as appropriate	Ongoing medication	Single prescription	Pharmacy purchase

Medication

Name/type of medication (as described on the container)		
Expiry date		
Dosage details		
Possible side effects		
Self-administration	Yes	No
Procedures to take in an emergency		

NB: Medicines must be in the original container as dispensed by the pharmacy. First dose **cannot** be administered in school.

Contact Details (to be completed only if **different** from details held already in school records SIMS)

Name	
Daytime telephone no.	
Relationship to student	

Special precautions/other instructions

Declaration of Parent or Carer

I understand that the medication must be delivered to a member of staff by a parent/carer.

I confirm that the first dose of this medicine (or the first dose after any change of medication) has been administered at home and there have been no ill effects or allergic reactions.

I confirm that any non-prescription medication has been administered previously and there have been no ill effects or allergic reactions. There has been no change to the medication, brand or dosage.

I confirm that the child's doctor or pharmacist has confirmed that the medication is appropriate, safe and necessary.

All information on this form is, to the best of my knowledge, accurate at the time of writing. I give consent to school staff to administer the medication in accordance with the school policy. I will inform the school in writing, immediately, if there is any change in dosage, frequency or medication.

Signature …… Date……..

Print name ……

Date	Time	Administered by	Signed

Date	Time	Administered by	Signed