

## VAUGHAN PRIMARY SCHOOL

### Section A: General

|                |                          |
|----------------|--------------------------|
| Name:          | Class:                   |
| Date of Birth: | Any known drug allergies |

### Section B: Medicine

Is this prescription medication? .....

What is the medical condition this medication is required for? .....

Has your child had this medication without side effects?.....

| <b>Medicine</b><br>(use name on label of medicine) | <b>Dosage</b><br>(be accurate e.g 10mls, thin layer on skin ) | <b>When to give</b> (be specific , e.g.. give only if required, or time to be given) | Have you given your child this medication today? If yes, what is the dose? |
|--|---|--|--|
|  |   |  |  |
|  |   |  |  |
|  |   |  |  |
|  |   |  |  |
|  |   |  |  |

### Section C: Consent

I .....(Print name), consent to the administration of the above named medication. I recognise that staff are doing so on a voluntarily basis and are not medically qualified.

**Name of child** .....

**Signed**.....

**Date** .....

**Contact telephone number**.....

Please note unless all above sections are complete under the school Supporting Child in Policy we are unable to administer any medication. Please can you tick the following before submitting if you have met these conditions.

|   |             |  |
|---|-------------|--|
| Have you completed all sections ABC?  | Please tick |  |
| Any medication must be sent in the original packaging with dose and expiry date clearly visible. All prescribed medicines (given by a doctor) need a pharmacy label. Over the counter medicines must have been given previously at home without side effects. | Please tick |  |

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Office use only.....

Section ABC completed.....

Pharmacy label if prescription.....

HCP if required? .....

Notes.....

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