

**Oxford High Senior school, Prep school and Early Years Foundation Stage**

**Consent to Administer Prescribed or Over the Counter Medication in School**

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| Pupil surname: |  | Pupil forename: |  |
| Date of birth: |  | Class/form: |  |
| Medical condition or illness medication required for: |  |
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| **MEDICATION** – *If more than one medicine is to be given a* ***separate form*** *should be completed for* ***each****. A new form is required for each new course of prescribed medication.* |
| **All prescribed medication must** be in the original container and packaging as dispensed by the pharmacy. The **pharmacy label** stating pupil’s name, dose and time to be given **must** be attached. *If this is not adhered to the staff will not be able to administer the medication.* |  | **Over the counter medicines supplied by parents** such as paracetamol, ibuprofen, throat lozenges, antihistamine, E45 cream **must** be in the original container, with the medicine details (product name, expiry date, dose, method and frequency of administration) clear on the label. The pupil’s name **must** be clearly written on the packaging. |
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| Name of medicine to be given by the nurse/nominated staff. |  |
| Expiry date of medication: |  |
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| **DIRECTIONS FOR USE** |
| First dose to be given on (day/date): e.g antibiotic therapy |  |
| Last dose to be given on (day/date): |  |
| Dosage: |  |
| Method of administration (e.g. oral/inhaled): |  |
| Time to be administered: |  |
| Special instructions/ precautions provided by prescriber: |  |
| Any potential side effects the school needs to know about: |  |
| Self-administration consented to by parent / guardian | Yes / No *(please delete as applicable)* |
| Procedures to take in an emergency: |  |
|  |  |
| The above information is, to the best of my knowledge, accurate at the time of writing and **I give consent for school staff to administer medicine in accordance with the school policy**. I will inform the school immediately, in writing, if any change in dosage or frequency of the medication is required, or if the medicine is stopped. |
| *Parent/guardian*Signed: | *Parent/guardian* Name: | Date: |

**Oxford High School**

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| **Date** | **Pupil’s Name** | **Time** | **Name of Medicine** | **Dose Given** | **Signature of Staff** |
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**Record of medicine administered to a pupil**