**Mayfield School Medicine Administering Form**

***The school will not give your child medicine unless you complete and sign this form***

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| --- | --- |
| Date for review to be initiated by |  |
| Name of child |  |
| Date of birth |  |
| Group/class/form |  |
| Medical condition or illness |  |
| **Medicine** | |
| Name/type of medicine (as described on the container) |  |
| Expiry date |  |
| Dosage and method |  |
| Timing |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school/setting needs to know about? |  |
| Self-administration | Y/N |
| Procedures to take in an emergency |  |
| **NB: Medicines must be in the original container as dispensed by the pharmacy** | |
| **Contact details** | |
| Name |  |
| Daytime telephone number |  |
| Relationship to child |  |
| Address |  |
| I understand that I must deliver the medicine personally to | Enter name of agreed member of staff: |

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

|  |  |
| --- | --- |
| Signature: | Date: |