Short Term Medication Declaration

The Ferrars Academy
Macaulay Road
Luton
LU4 0LL
Principal: Miss Sarah Green

I give permission for a member of staff of The Ferrars Academy to administer medicine.
All prescribed medicines must be in the original container as dispensed by the pharmacy, with the child's name, the name of the medicine, the dose and the frequency of administration, the expiry date and the date of dispensing included on the pharmacy label. Please use a separate sheet for each medication.

Name of Child: ……

Class: …….. Date of Birth: ……

Name of Medication: ……

Dosage: ……

Time Medication to be given: ……

Date(s): …… to ……

Reason for requiring medication: ……

……

Please tick appropriate box
Medicine to be left at the Academy ☐

Medicine to be taken home each day
(Must be collected and delivered by an adult each day) ☐

In consideration of the Principal or the Academy's staff agreeing to supervise my/our above named child taking medication during school hours. I/we agree to indemnify the Principal and the Academy staff against all claims, costs, actions and demands whatsoever resulting from this supervision unless such claims, costs, actions and demands result out of the negligence of the Principal or the Academy staff. I confirm that the information provided is accurate and to be administered as stated above. If changes should occur the Academy needs to be notified at once.

Signed: …… Relationship to Child: ……

Contact Number: …… Date: ……

Updated 07.11.18

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Short-Term Medication Record

Childs Name:			Class:		
Name of Medication:					
Date:	**Time:**	**Details of Dosage:**	**Responsible Named person:**	**Witnessed by: (if applicable)**	**Parent signed:**

Medication returned to parent on: ……/…../…… **Staff Signature: ……**

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Childs Name:			Class:		
Name of Medication:					
Date:	**Time:**	**Details of Dosage:**	**Responsible Named person:**	**Witnessed by: (if applicable)**	**Parent signed:**

Medication returned to parent on: ……/…../…… **Staff Signature: ……**