**Parental/Carer Agreement to Administer an ‘Over the Counter’ (OTC) Medicine Bleak Hill**

Head Teacher Mr McCoy/ Senior First Aider Mrs D Aspinall-Wood

* All over the counter (OTC) medicines must be in the original container.
* This form my only be used for Temporary Pain relief/Temperature control (above 37c) / Allergy Medication and Travel Sickness Tablets all other medication must be prescribed

**The school will not administer the first dose in case of a reaction to the medication**

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| **Child’s name** |  |
| **Child’s date of birth** |  |
| **Class** |  |
| **Name of medicine & strength of medicine 1** |  |
| **How much (dose) to be given. For example: One tablet, One 5ml spoonful** |  |
| **At what time(s) the medication should be given** |  |
| **Reason for medication** |  |
| **Name of medicine & strength of medicine 2** |  |
| **How much (dose) to be given. For example: One tablet, One 5ml spoonful** |  |
| **At what time(s) the medication should be given** |  |
| **Reason for medication** |  |
| Are there any possible side effects that the school needs to know about? If yes, please list them |  |

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| **Mobile number of parent/carer** |  |
| **Daytime landline for parent/carer** |  |
| **Alternative emergency contact name** |  |
| **Alternative emergency phone no.** |  |
| **Name of child’s GP practice** |  |
| **Phone no. of child’s GP practice** |  |

* I give my permission for a first aider to administer the prescribed medicine to my child during the time they are in school.
* I confirm that the dose and frequency requested is in line with the manufacturers’ instructions on the medicine.
* I understand that medical advice may need to be sought after a period of time recommended by the manufacturer and school will only be able to continue with medication for longer than this once prescribed.
* The above information is, to the best of my knowledge, accurate at the time of writing.

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| **Parent/carer name** |  |
| **Parent/carer signature** |  |
| **Date** |  |