

# Alma Primary Medication Form (Occasional)

## Parental Consent For A Child To Receive Medication In School



**Alma Primary**  
עולם חסד יבנה  
A world built on kindness

Except in exceptional circumstances (e.g. a specified health care plan), we will only administer medication as follows:

- Medication not prescribed by a doctor is subject to approval by the Headteacher
- Medication will only be administered **once** during normal school hours and only if required **FOUR** times a day
- First doses of any antibiotic must be given at home and the first 24 hour of doses must be given by a parent/carer
- Medication must be given to the office in its original packaging, with this form and any additional information e.g. Dr's note

Child's name			D.O.B.		Class	
Name of Medication (as described on the container)						
Medication form i.e. liquid, tablets, capsules		Storage instructions				
Date & time of first dose/application (must be at home)		Expected date of last dose/application				
Dosage, method and timings of taking medication at school	(please give as much detail as possible)					

### Permission:

- I consent to my child being administered the medication above, during school hours.
- I undertake to ensure that the school has adequate supplies of the medication/equipment.
- I undertake to ensure that the medication/equipment supplied by me and prescribed by my child's doctor is correctly labelled, in date, with storage details attached and to inform the school of any changes.
- I understand that the medication/procedure will be administered according to the instructions given above.

Signed (Parent/Carer): \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Office Use Only

Label checked		Storage instructions checked		Dosage checked		Expiry date (as stated on container)	
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### Quantity of medication **received** i.e. half a bottle (checked each day medication is brought to school)

Day 1 Date/Quantity/Staff initials	Day 2 Date/Quantity/Staff initials	Day 3 Date/Quantity/Staff initials	Day 4 Date/Quantity/Staff initials	Day 5 Date/Quantity/Staff initials

### Quantity of medication **returned** i.e. half a bottle (checked each day medication is taken home from school)

Day 1 Date/Quantity/Staff initials	Day 2 Date/Quantity/Staff initials	Day 3 Date/Quantity/Staff initials	Day 4 Date/Quantity/Staff initials	Day 5 Date/Quantity/Staff initials

Consent given by Headteacher (if applicable) Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Date	Time given	Dose given	Staff Member 1	Staff Member 2