RIVERDALE PRIMARY SCHOOL

Name of child:	Year:	
Name of medication:		
PLEASE COMPLETE ALL RELEVANT SECTIONS.		
Has the medication: a) Been prescribed by a doctor? If yes, go to Section A. b) Been bought over the counter at the pharmacy or supermarket? If yes, go to Section B.		
Section A – Prescribed Medication On the medication:	YES	NO
1) Is there written evidence that the medicines/tablets to be administered have been prescribed by a doctor?		
Does the container of the medicine or tablets have a label which give:		
✓ The name of the prescribing person i.e. the doctor?		
✓ The name of the pupil?		
✓ The name of the medicine/tablets?		
✓ The amount to be administered?		
✓ The time of administration i.e. 3 or 4 times a day **Please also let us know what time of day your child will require the medication.**		
2) Has written authorisation been obtained from the parent/guardian for the medicine/tablets to be administered to the pupil?		
Does the parent's written authorisation cover:		
✓ Medicine		
✓ Tablets		
3) Do the medicine or tablets which are detailed in the parent's written authorisation correspond with the medicine/tablets in the pupil's possession?		
4) Does the name of the pupil who is being given the medicine/tablets correspond with the name on the label of the medicine/tablet container and the parent's authorisation?		
5) Are the tablets/medicine to be stored in the medicine cupboard or in the refrigerator in the school office?		
Section B – Non-prescribed medication On the medication does it clearly show:	YES	NO
1) ✓ The name of the pupil?		
✓ The name of the medicine/tablets?		
✓ The amount to be administered?		
✓ The time of administration?		
2) Are the tablets/medicine to be stored in the medicine cupboard or in the refrigerator in the school office?		
By completing this form you are consenting to members of the school staff administrating the medication detailed above to your child.		
Signed:	Date	

MEDICATION – DROP OFF/COLLECTION

(Please record when medication is dropped off and collected by parents/carers)

DATE	Dropped off by	Signature	DATE	Collected by	Signature

THIS SECTION IS TO BE FILLED IN BY THE MEMBER OF STAFF ADMINISTERING THE MEDICATION

Member of Staff	Checked By	DATE	TIME	Member of Staff	Checked By	DATE	TIME

Notes: *(Please use this space to record any child's refusal take the medication, side effects that have been noted and reported to parents etc.)*

DISPOSAL OF MEDICATION

It is the responsibility of the parent/carer to dispose of medication. In the event that the parent/carer fails to collect the medication from school for disposal, the medication should handed over to a local Pharmacy for them to dispose of.

	Date:
Name of person disposing of medication:	
If handing over to a pharmacy – name & address of Pharmacy.	