MIDDLETON SCHOOL

Confirmation of the Headteacher's agreement to administer medication

It is agreed that …………………………………………. (name of child) will receive

……………………………………………… (quantity and name of medicine) every day at

……………………….. (time medicine to be administered).

This arrangement will continue until ……………………………………………..

(either end date of course of medicine or until instructed by parents)

Date: ……………………………………………………….

Signed: ……………………………………………………..
Headteacher

MIDDLETON SCHOOL

Contact Details

Name: ……………………………………………………………………………………..

Daytime Telephone Number: ………………………………………………………………

Relationship to child: …………………………………………………………………….

Address: ………………………………………………………………………………….

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to 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.

Parent's signature: ……………………………………………………………………….

Print Name: ………………………………………………………………………………

Date: ……………………………………………………………………………………….

If more than one medicine is to be given a separate form should be completed for each one.

MIDDLETON SCHOOL

Parental agreement for school to administer medicine

Middleton School will not give your child medication unless you complete and sign this form.

Child's Name: ……………………………………………………………………………

Date of Birth: ……………………………………………………………………………

Class: ………………………………………………………………………………………

Medical condition / illness: ………………………………………………………………

Name and strength of medicine: …………………………………………………………

Date dispensed: …………………………………………………………………………

Expiry date: ……………………………………………………………………………

Dose to be given and method: …………………………………………………………

When to be given: ………………………………………………………………………

Any other instructions: …………………………………………………………………

Self Administration: YES / NO (delete as appropriate)

Are there any side effects that we need to know about? ………………………………………………………………

Procedures to take in an emergency: ……………………………………………………

Name and telephone number of GP: ……………………………………………………

Note: Medication must be in the original container as dispensed by the pharmacy

Signed: ………………………………………….. Date: ……………………………

Parent / Carer Name: …………………………………………………………………….

Middleton School

Authorization for the administration of Buccal Medazolam

Name of School: ……………………………………………………………………………

Child's name: ………………………………………………………………………………

Date of Birth: ………………………………………………………………………………

Home Address: ……………………………………………………………………………

……………………………………………………………………………………………………

GP: ……………………………………………………………………………………………

Hospital Consultant: ………………………………………………………………………

………………………… (name of child) should be given Buccal Medazolam ……mg. If he / she has a *prolonged epileptic seizure lasting over …………… minutes

OR

***serial seizures lasting over ………………… minutes.**

An ambulance should be called for *at the beginning of the seizure

OR

If the seizure has not resolved *after …………………. minutes.

(*Please delete as appropriate)

Doctor's signature: ……………………………………………………………………

Parent's signature: ……………………………………………………………………

Print Name: ……………………………………………………………………………

Date: …………………………………………………………………………………………