APPENDIX 1

MED1

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you have completed and signed this form and the Head Teacher has agreed that school staff can administer the medication.

1. DETAILS OF PUPIL

Pupil's name: _____ Date of birth: _____

Address: _____

_____

_____

School: _____ Class _____

Tel No: Home: _____ Emergency: _____

2. DETAILS OF MEDICATION

Condition or illness: _____

Name/Type of medication _____
(as described on the container)

Prescribed by: (please tick as appropriate)

☐ GP Name: _____

Address: _____

☐ Hospital Name: _____

Address: _____

☐ Other Name: _____

Address: _____

For how long will your child take this medication? _____

Full directions for use: .....

Dosage and method: .....

Times at which medicine(s): to be given .....

Special precautions: .....

Side effects: .....

Expiry date: .....

Procedures to be taken in an emergency: (e.g. asthma – maximum number of doses to be administered for treatment of acute wheezing)

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3. STAFF INDEMNITY

"Midlothian Council hereby indemnifies all authorised staff at the school from and against claims for alleged negligent actions, costs, charges, losses, damages and expenses which they or any of them shall or may incur or sustain by reason of any alleged negligent act or omission by them in the administration of the medication to the Pupil, provided always that the alleged negligent act or omission was done in the course of their employment."

4. PARENTAL RESPONSIBILITY

(i) I understand that I must deliver the medicine(s) personally to you, and to replace them wherever necessary and accept that this is a service which the school is not obliged to undertake.

(ii) I accept responsibility for advising you immediately of any change of treatment prescribed by any doctor or hospital.

(iii) I understand the terms of the Staff Indemnity.

Signature: ……..... Date: .....
Parent/Carer

Date Received by School: ……..... Signature: …….....
Head Teacher

ACTION TAKEN

APPENDIX 2

MED2

REQUEST FOR MEDICATION TO BE SELF ADMINISTERED

This form must be completed by parents/carers of pupils under 16

1. DETAILS OF PUPIL

Pupil's name: _____ Date of birth: _____

Address: _____

_____

_____

School: _____ Class _____

Tel No: Home: _____ Emergency: _____

2. DETAILS OF MEDICATION

Condition or illness: _____

Name/Type of medication _____
(as described on the container)

Prescribed by: (please tick as appropriate)

☐ GP Name: _____

Address: _____

☐ Hospital Name: _____

Address: _____

☐ Other Name: _____

Address: _____

For how long will your child take this medication? _____

Full directions for use: .....

Dosage and method: .....

Times at which medicine(s): to be given .....

Special precautions: .....

Side effects: .....

Expiry Date: .....

Procedures to be taken in an emergency: (e.g. asthma – maximum number of doses to be administered for treatment of acute wheezing)

.....

.....

.....

3. PARENTAL RESPONSIBILITY

(i) I would like my daughter/son to keep her/his medication on her/him for use as necessary.

(ii) I understand that I must deliver the medicine(s) personally to you and to replace them wherever necessary

Delete (i) or (ii) as appropriate.

(iii) I accept responsibility for advising you immediately of any change of treatment prescribed by any doctor or hospital.

Signature: ……..... Date: .....
Parent/Carer

.....

Date Received by School: ……..... Signature: …….....
Head Teacher

ACTION TAKEN