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

Oakdene Primary School

Headteacher: Ms L Young

* All over the counter (OTC) medicines must be in the original container with enclosed leaflet.
* A separate form is required for **each medicine**.

**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/form** |  |
| **Today’s Date** |  |
| **Name of medicine** |  |
| **I confirm that this medicine has been administered previously with no adverse effect.** | YES / NO |
| **Strength of medicine** |  |
| **Special storage instructions?** |  |
| **How much (dose) to be given. For example:** 1 tablet**,** 5ml  |  |
| **At what time(s) the medication should be given** |  |
| **Reason for medication** |  |
| **Duration of medicine**Please specify how long your child needs to take the medication for |  |
| Are there any possible side effects that the school needs to know about? If yes, please list them |  |
| **Details of this or any similar medications taken in the last 24 hours.** |  |

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| I confirm that approval has been given by the child’s GP to take this medicine concurrently with their prescription medication. | Yes |  |
| No |  |
| Not applicable |  |

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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 the Headteacher (or his/her nominee) to administer the OTC medicine to my son/daughter during the time he/she is at school/nursery. 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 no longer needed.
* I understand that it may be necessary for this medicine to be administered during educational visits and other out of school/nursery activities, as well as on the school/nursery premises.
* **I confirm that the dose and frequency requested is in line with the manufacturers’ instructions on the medicine.**
* I also agree that I am responsible for collecting any unused or out of date medicines and returning them to the pharmacy for disposal. If the medicine is still required, it is my responsibility to obtain new stock for the school.
* 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** |  |

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| Authorised to be administered in accordance with policy, by  | Oakdene Office:  |
| Signature |  |
| Date |  |

**Record of Medicine Administered to an Individual Child**

Oakdene Primary School

Headteacher: Ms L Young

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| Child’s Name |  |
| Name of Medicine |  |
| Date Medicine provided by Parent |  |
| Expiry Date |  |

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| Date  | Time Given  | Dose Given | Given By Witnessed by | Reason Not Given  |
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| Date  | Time Given  | Dose Given | Given By Witnessed by | Reason Not Given  |
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