*FORM A*

**ST NICHOLAS CATHOLIC HIGH SCHOOL**

Medication Consent & Administration Log.

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

Student Name…………………………………………………………………….. Date of Birth……………….

Address……………………………………………………………………………. Form………………………..

………………………………………………………………………………………

………………………………………………………………………………………

Known Allergies…………………………………………………….GP Name………………………………….

|  |  |
| --- | --- |
| Family Contact 1 | Family Contact 2 |
| Name………………………………………………….  Relationship to student……………………………..  Address……………………………………………….  …………………………………………………………  Tel Home……………………………………………..  Tel Work………………………………………………  Tel Mobile……………………………………………. | Name………………………………………………….  Relationship to student……………………………..  Address……………………………………………….  …………………………………………………………  Tel Home……………………………………………..  Tel Work………………………………………………  Tel Mobile……………………………………………. |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medical Condition or Illness……………………………………………………………………………………...  ………………………………………………………………………………………………………………………  Medication Name (as on prescribed container)………………………………………………………………..  Strength of medication……………………………………………………………………………………………   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Date Received in School | Received By | Name of Person Delivering Medication | Amount Supplied | Expiry Date | Signature (School) | Signature (Parent/Guardian) | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |

|  |
| --- |
| Name of medication………………………………………………………………………………………………  Strength of medication……………………………………………………………………………………………  How long will your child use this medication……………………………………………………………….....  Directions for use  Dosage to be given……………………………………………………………………………………………….  Time to be given…………………………………………………………………………………………………..  Special precautions……………………………………………………………………………………………….  Side Effects………………………………………………………………………………………………………..  Procedure to take in an emergency…………………………………………………………………………….  Review date……………………………………………………………………………………………………….   * I confirm my child has taken the above medication for a minimum of 24 hours and has not shown any adverse effects. * I accept this is not a service the school is obliged to undertake. * I understand that only medicines supplied in the original container as dispensed by the pharmacy will be accepted. * The above information is, to the best of my knowledge, accurate at the time of writing and I give consent for the school to administer the above medication in accordance with the school policy. I will inform the school of any changes to the above in writing.   Signed…………………………………………………………Date……………………………......................  Print name…………………………………………………….Relationship to child………………………….. |

|  |
| --- |
| Head Teacher/ Designated member of staff agreement to administering the above medication  Signed………………………………………………………….Date…………………………………………….. |

**Register of Medication Administered.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Time** | **Name and strength of medication** | **Quantity given** | **Amount left** | **Given by** | **Comments** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |
| --- |
| Quantity returned to parent/guardian……………………………………………………………………………  Date returned………………………………………………………………………………………………………  Name of person collecting medication………………………………………………………………………….  Signature of person collecting medication………………………………………Date……………..…………  Returned by…………………………………………………………………………Date……………………….. |