*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………………………..

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

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| 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……………………………………………. |

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| Medical Condition or Illness……………………………………………………………………………………...………………………………………………………………………………………………………………………Medication Name (as on prescribed container)………………………………………………………………..Strength of medication……………………………………………………………………………………………

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| Date Received in School | Received By | Name of Person Delivering Medication | Amount Supplied | Expiry Date | Signature (School) | Signature (Parent/Guardian) |
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| Name of medication………………………………………………………………………………………………Strength of medication……………………………………………………………………………………………How long will your child use this medication……………………………………………………………….....Directions for useDosage 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………………………….. |

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

**Register of Medication Administered.**

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| **Date** | **Time** | **Name and strength of medication** | **Quantity given** | **Amount left** | **Given by** | **Comments** |
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| Quantity returned to parent/guardian……………………………………………………………………………Date returned………………………………………………………………………………………………………Name of person collecting medication………………………………………………………………………….Signature of person collecting medication………………………………………Date……………..…………Returned by…………………………………………………………………………Date……………………….. |