HASTINGS HIGH SCHOOL

Care and Excellence for All

General Care Plan

Parent/Guardian of……Full Name of Child

My child has been diagnosed as having:……(name of condition)

He/She has been considered fit for school but requires the following prescribed medicine to be administered during school hours:

…… (name of medication)

I allow/do not allow for my child to carry out self administration (delete as appropriate)

Could you please therefore administer the medication as indicated above

…… (dosage) at …… (timed)

With effect from .....Until advised otherwise.

The medicine should be administered by mouth/in the ear/nasally/other..... (delete as applicable)

I allow/do not allow for my child to carry the medication upon themselves (delete as appropriate)

I undertake to update the school with any changes in routine, use or dosage or emergency medication and to maintain an in date supply of the prescribed medication.

I understand that the school cannot undertake to monitor the use of self administered medication of that carried by the child and that the school is not responsible for any loss of/or damage to any medication.

I understand that if I do not allow my child to carry the medication it will be stored by the School and administered by staff with the exception of emergency medication which will be near the child at all times.

I understand that staff may be acting voluntarily in administering medicines to children.

Signed……

Date……

Name of parent (please print)

……

Contact Details

Home…… Work……

Mobile……