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**Request for medication to be administered on a long-term basis**

**PART 1: CHILD’S DETAILS**

CHILD’S NAME: ........................................................... ...........................................................

Date of Birth: ...........................................................

Child’s Class: ...........................................................

DESCRIPTION OF MEDICAL CONDITION:

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**PART 2: EMERGENCY CONTACT INFORMATION**

CONTACT 1

Name .................................................................

Daytime Telephone Number....................................................................

Mobile Telephone Number.........................................................

Relationship to child............................................................................... Address...................................................................................................................... ............

Postcode .......................................

CONTACT 2

Name .................................................................

Daytime Telephone Number....................................................................

Mobile Telephone Number.........................................................

Relationship to child............................................................................... Address...................................................................................................................... ............

Postcode .......................................

Name of Prescribing Doctor................................................................... .................................

Address of Prescribing Doctor…………………………………………………………………

Telephone of Prescribing Doctor…………………………………………………………………

**PART 3: DESCRIPTION OF CONDITION AND DETAILS OF CHILD’S INDIVIDUAL SYMPTOMS**

MEDICATION REQUIRED:

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DETAILS OF DOSE:

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METHOD, TIME AND ADMINISTRATION:

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DAILY CARE REQUIREMENTS (eg before sport, dietary, therapy, nursing needs):

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ACTION TO BE TAKEN IN AN EMERGENCY:

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FOLLOW-UP CARE:

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COMMENTS ON PUPIL’S ABILITY TO SELF-ADMINISTER MEDICATION:

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MEMBERS OF SYS STAFF WHO HAVE VOLUNTEERED TO ADMINISTER MEDICATION (ensure that parents understand the indemnity details shown below):

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STAFF TRAINING NEEDS:

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**STAFF INDEMNITY**

SET YOUR SIGHTS indemnifies and holds harmless all staff from and against all actions, costs, charges, losses, damages and expenses which any of them shall or may incur or sustain by reason of any act or omission in the administration of medication to the child in the course of their employment.

**PART 4: PARENTAL AGREEMENT**

I agree that the medical information contained in this form may be shared with individuals involved with the care and education of my child.

Signed (parent/carer) ......................................................................................................................

Name (parent/carer) ......................................................................................................................

Date ...............................................................................................................................................