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**Pharmacy support within Hadrian School and Sir Charles Parson’s (SCP) for children with special educational needs and disabilities (SEND)**

**Dear Parent/Guardian,**

We are writing to parents/guardians to introduce a pilot service available at Hadrian School and SCP.

As part of this pilot service, a Pharmacy Team will work with you, the school and the school Nursing Team (provided consent is agreed), to ensure safe and effective use of medicines in school.

Some of the benefits to signing up to this pilot service include:

* Enabling us to update GP records in a timely manner after hospital visits/clinic appointments which would be of great benefit to the care of your child/young person
* Supporting parents/guardians in arranging supply of medicines at the school during term time for your child/young person.

We are seeking permission from you to access your child/young person’s patient records to:

* Support the safe and effective use of medicines
* Improve patient/pupil medicines safety in schools
* Speak with secondary care (hospital) consultants to resolve medication queries.

Our pilot project is about supporting children and young people ensuring that they get the best possible outcomes from their medicines while in their school environment. If you have any further questions, please contact Mr C Rollings at school.

**To enable us to provide this service, we would like to ask you, the parent/guardian, to consent to allow us access to your child’s medical GP Practice records**.

I the parent/Guardian confirm that I give consent for the Pharmacy Team to access my child’s/young person’s medical records.

**Child’s name in full. Block capitals- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s Date of Birth- Day/ Month/ Year-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parental/ Guardian’s Full name -\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parental/ Guardian’s Signature- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of signature\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**You have the option to withdrawn consent at any time in writing.**

Please return this form to Admin at Hadrian school as soon as possible. Many thanks **SEND Pharmacy Team, CBC Health Federation**