Parental Consent for School to Administer Medicine

The School will not give your child medicine unless you complete and sign this form, and has a policy that staff can administer medicine, and staff consent to do this.

Note: Medicines must be in the original container as dispensed by the pharmacy

Name of School	
Date	Day / Month / Year
Childs name	
Date of birth	Day / Month / Year
Group/Class/Form	
Medical condition or illness	

Medicine

Name/type of medicine/strength *(as described on the container)*	
Date dispensed	Day / Month / Year
Expiry date	Day / Month / Year
Agreed review date to be initiated by (name of member of staff) (LONG TERM MEDICATION ONLY)	
Dosage and method	
Timing – when to be given	
Special precautions	
Any other instructions	
Number of tablets/quantity to be given to School/Setting	
Are there any side effects that the School/Setting needs to know about?	
Self administration	Yes / No (*delete as appropriate*)
Procedures to take in an emergency	

Contact Details – First Contact

Name	
Daytime telephone number	

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Contact Details – Second Contact

Name

Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Name and phone number of G.P.

The above information is, to be the best of my knowledge, accurate at the time of writing and I give consent to School/Setting staff administering medicine in accordance with the School/Setting policy. I will inform the School/Setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I accept that this is a service that the School/Setting is not obliged to undertake.
I understand that I must notify the School/Setting of any changes in writing

Date _____ Signature(s) _____

Parent's signature _____

Print name _____

Date _____

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

For School Use Only

Checked by	Date	Signature	Print Name

To be reviewed annually or if dose changes (LONG TERM MEDICATION ONLY)