



Parental Consent for School Administration of Medication

Date:.....

Pupil Details

Surname: Forename:

Address:

Date of Birth: Class:

Condition/Illness:

Name of Medicine :Duration of Course:

Dose Prescribed :Date Prescribed :

Time(s) to be given :

Self administration:

Known side effects:

Any procedures to take in an emergency:

The above medication has been prescribed by the family or hospital doctor. It is clearly labelled indicating contents, dosage and child's name in FULL. I understand that the medicine must be delivered to the school by myself or the under mentioned responsible adult

.....

and accept that this is a service which the school is not obliged to undertake and also agree to inform the school of any change in dosage immediately. I also understand and accept that, whilst every endeavour will be made by the member of staff to administer the medication at the correct time, occasionally unforeseen circumstances can arise in school which may result in the medication being administered late or not at all.

Contact Details:

Name: Daytime phone number:

Address:

Relationship to child: Signed:

Notes to Parents:

- 1 Medication will not be accepted by the school unless this form is completed and signed by the parent or legal guardian of the child and that the administration of the medicine is agreed by the Headteacher.
- 2 This agreement will be reviewed on a termly basis.
- 3 The Governors and Headteacher reserve the right to withdraw this service.