PARENTAL CONSENT FOR ADMINISTRATION OF MEDICINES

The school can only give your child medication when we receive this signed form from you and when the Head Teacher has agreed that school staff can administer the medication.

All medicines **must** remain in their original containers/packaging and include any necessary equipment required to administer the medicine.

Student's Name: …… Date of Birth: ……..…

Address ……..…

Contact Telephone No (s): ……

Name of Doctor & Telephone No: …….

I agree to members of staff administering medicines, first aid and emergency treatment to my child as directed below or in the case of an emergency, as staff may consider necessary.

I understand that I must ensure the medicine is taken to either reception or the medical room and handed to a member of staff on arrival at school. I agree that it is my responsibility that the medication is collected at the end of the school day if it is required at home. I accept that this is a service which the school is not obliged to undertake.

I recognise that school staff are not medically trained.

Name of medication	Dosage	Times to be Given	Last Administration Date

Special Instructions to be followed:

Signature: …….. (Parent/carer)

Print Name ……..…… Date ……

RECORD OF ADMINISTRATION OF MEDICINES

Student Name: ……………………………………………………………………………..

Date			
Name of medication			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Name of medication			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Name of medication			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Name of medication			
Time given			
Dose given			
Name of member of staff			
Staff initials			