**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 | | | Ashbourne Hilltop Primary | |
|  | | |  | |
| 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 | | |  | |
|  | | |  | |
| 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)