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)