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Only Complete if Student has to take Medicines in School

**PARENTAL CONSENT**

**ADMINISTRATION OF MEDICINES IN SCHOOL**

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT DRUGS ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF OR WHERE A CHILD IS BRINGING MEDICINE INTO SCHOOL WHICH THEY WILL SELF- ADMINISTER.

If you need help to complete this form, please contact the school.

Please complete in block letters

|  |  |
| --- | --- |
| Name of Child |  |
| Date of Birth |  |
| Address |  |
| Doctor’s Name |  |
| Doctors Address |  |
| Name of person completing form |  |
| Relationship to child |  |

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**NON-PRESCRIBED MEDICINES**

My child requires the following non-prescribed medicines:

1. Name of drug or medicine to be given.

2. When? (e.g. lunchtime? after food? when wheezy? before exercise?).

3. How much? (e.g. half a teaspoon? 1 tablet? 2 drops?).

4. Route, e.g. by mouth or in each ear.

5. Any special storage instructions?

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | When? | How much? | Route? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Storage instructions

**PRESCRIBED MEDICINES**

**The Doctor has prescribed (as follows) for my child:**

1. Name of drug or medicine to be given.

2. When? (e.g. lunchtime? after food? when wheezy? before exercise?).

3. How much? (e.g. half a teaspoon? 1 tablet? 2 drops?).

4. Route, e.g. by mouth or in each ear.

5. Any special storage instructions?

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | When? | How much? | Route? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Storage instructions

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**ADMINISTRATION OF MEDICINES IN SCHOOL**

**(Child's Name)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

can administer his/her own medication\*/requires supervision to administer his/her own medicine\*/requires assistance in administering his/her medicine\*.

I request that the treatment be given in accordance with the above information by a named member of the school staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out-of- school activities, as well as on the school premises.

**I undertake to supply the school with the drugs and medicines in the original duplicate labelled containers, provided by the Dispensing Chemist.**

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent and that the school staff may, therefore, need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

I can be contacted at the following address/telephone during school hours:

|  |  |
| --- | --- |
| Name (1) |  |
| Contact Address |  |
| Emergency Contact Number (1) |  |

|  |  |
| --- | --- |
| Name (2) |  |
| Contact Address |  |
| Emergency Contact Number (2) |  |

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Delete that which does not apply

**IT IS THE RESPONSIBILITY OF THE PERSON COMPLETING THIS FORM TO UPDATE THE SCHOOL OF ANY CHANGES AND TO ENSURE THAT MEDICATION IS AVALIABLE FOR AS LONG AS REQUIRED.**

**THIS FORM SHOULD BE DISCARDED/DESTROYED WHEN THE MEDICATION IS COMPLETED OR CHANGED.**