



Parental Consent Form for school to administer medicines

The school will not give your child medicine unless you complete and sign this form.
The Head teacher must also agree to permit and support any school staff who might volunteer to administer the medication with the appropriate training/instruction.

Date by which review to be initiated	
Name of school	
Name of pupil	
Date of birth	
Medical condition or illness	

Medicine

Name/type of medicine <i>(as described on the container)</i>	
Expiry date	
Dosage and method	
Timing	
For how long will your child take this medication?	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration?	YES/NO (please indicate)
Procedures to take in an emergency	

NB. Medicines must be in the original container as dispensed by the pharmacy

Contact details

Name	
Daytime telephone no.	
Relationship to pupil	
Address	

The above information is, to 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 policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication, or if the medicine is stopped.

Signature(s) _____ Relationship to student _____

Name of signatory (Print) _____ Date _____

DATE	TIME	DOSE / COMMENTS	STAFF NAME	SIGNATURE