PARENTAL CONSENT FORM FOR THE ADMINISTRATION OF MEDICINES

SECTION 1

PUPIL NAME ____________________

CLASS No/ TEACHER ____________________

DATE OF REQUEST

SECTION 2

PARENT CONTACT NUMBER ____________________

DAY TIME EMERGENCY CONTACT NUMBER ____________________

PARENT(S) OR CARER(S) NAME

SECTION 3

NAME OF MEDICATION ____________________

IS THIS MEDICINE: TICK TO CONFIRM MEDICINE IS PRESCRIBED ☐

CONDITION OR ILLNESS EG EAR INFECTION ____________________

DATE PRESCRIBED ____________________

DETAILS OF DOSAGE ____________________

TIME/FREQUENCY OF DOSAGE ____________________

DATE COURSE OF MEDICATION FINISHES ____________________

If the medication is prescribed for 8 days or more, an individual health care plan should be completed.

SECTION 4

DECLARATION BY THE PARENT/LEGAL GUARDIAN

I consent to my child being administered the prescribed medicine in accordance with the information above. *I understand that It is the School Policy not to force children to take their medicine if they refuse to do so. In the event of this occurring, the nominated contact will be notified.*

I understand that the LEA, Governing Body of the school and the staff cannot accept responsibility for any adverse reaction my child may suffer as a consequence of being administered the prescribed medication at my request.

Signed: ____________________ Date: ____________________.

Relationship to child: ____________________

SECTION 5

APPROVAL FOR REQUEST YES / NO

HEADTEACHER______________________________ **DATE**______________________________

RECORD OF PRESCRIBED AND NON PRESCRIBED MEDICINES ADMINISTERED TO CHILDREN OR SELF ADMINISTERED AS PER PAGE 1

DATE	TIME	MEDICINE & DOSAGE	ADMINISTERED BY	WITNESSED BY