Parental Consent Form

To be completed by the Parent/Carer of any child to whom medication may be administered under the supervision of school staff.

If you need help to complete this form please contact the School/setting or the Health Visitor attached to your Doctor's surgery.

Please complete in block letters:

Name of Child: .....

Date of Birth/Year Group/Class: .....

Address: .....

.....

Contact Details in an Emergency: .....

.....

Doctor's Name: .....

Doctor's Telephone Number: .....

A separate form MUST be completed if more than 2 medicines are to be administered.
I accept that I must deliver the medicine personally to the school office **(MEDICINES MUST NOT BE SENT INTO SCHOOL WITH THE PUPIL).** The information given is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff to administer the medicine in accordance with their policy. I will inform the school immediately if the medicine is to be stopped and, in writing from the Doctor, if there is any change in dosage or frequency of the medication to be given.

I understand it may be necessary for this treatment to be carried out during educational visits and other out of school activities as well as on school premises.

I undertake to supply the school with medicines in the original packaging, supplied by the dispensing chemist and, in a named sealed container.

I accept that whilst my child is in the care of the school setting, 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.

Parent/Carer Signature: .....

Date: .....

Please complete in block letters:

Name of Child: .....

Date of Birth/Year/Class: .....

Medical Diagnosis/Condition/Illness: .....

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The Doctor has prescribed the following for my child:

A) Regularly:

Name of Drug or Medicine: .....

How often (e.g. before or after lunch, before or after food): .....

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How much (e.g. 2.5ml, 5ml, 1 tablet): .....

Refrigeration Required **(Please indicate**): YES or NO.....

Date Medication to Commence: .....

Date Medication to Finish: .....

B) In Special Circumstances:

Please describe what circumstances and the nature and dosage of the prescribed medication or

treatment: .....

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<u>School Signature of Acceptance and Receipt of Medication:</u>

NAME: .....

ROLE IN SCHOOL: .....