



Parent Medication Consent Form

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

Medication **MUST** be in in date. In original packaging.

A separate form **MUST** be completed for each medication to be administered.

Please complete in block letters

Name of Child: Class:

Date of Birth:

Address:
.....

Emergency Contact Name: Tel

Doctor's Surgery & Number:

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

Name/type of Medicine:

Time (before or after food):

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

Refrigeration Required YES or NO (**please circle**)

Medication to return home/stay at school (**please circle**)

Date Medication to commence:

Date Medication to end:

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:.....

School Signature of Acceptance and Receipt of Medication:

Full Name: Role: