Parental Consent for school to Administer Medicine

The School will not give your child medicine unless you complete and sign this form, and has a policy that staff can administer medicine, and staff consent to this.

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

Name of School	Anthony Gell School
Date	Day / Month / Year
Child's Name	
Date of Birth	Day / Month / Year
Year Group and Tutor Group	
Medical condition or illness	
Medicine	
Name/type of medicine/strength (as described on the container)	
Date dispensed	Day / Month / Year
Expiry Date	Day / Month / Year
Agreed review date to be initiated by (name of member of staff) (LONG TERM MEDICATION ONLY)	
Dosage and method	
Timing – when to be given	
Special precautions	
Any other instructions	
Number of tablets/quantity to be given to school	
Are there any side effects that the school needs to know about?	
Self administration	Yes / No (delete as appropriate)

Procedures to take in an emergency

Contact Details – First Contact (usually a parent/carer)

Name

Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Contact Details – Second Contact

Name

Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Name and phone number of G.P.

The above information is, to be the best of my knowledge, accurate at the time of writing and I give consent to school 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.

I accept that this is a service that the school is not obliged to undertake.
I understand that I must notify the school of any changes in writing.

Date ____________________________ Signature(s) ____

Parent's signature____

Print Name ____ Date_________________________________

If more than one medicine is to be given a separate sheet should be completed for each one.

For School Use Only

Checked by	Date	Signature	Print Name

To be reviewed annually or if dose changes (LONG TERM MEDICATION ONLY)

SCHOOL MEDICINE RECORD

Date						
Time Given						
Teacher Initials						

Date						
Time Given						
Teacher Initials						

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