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:

PRESCRIBED		NON 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: ______________________