PARENTAL CONSENT
ADMINISTRATION OF MEDICINES IN SCHOOL

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT DRUGS ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF OR WHERE A CHILD IS BRINGING MEDICINE INTO SCHOOL WHICH THEY WILL SELF- ADMINISTER.

If you need help to complete this form, please contact the school. Please

complete in block letters

Name of Child _____Date of Birth _____

Address _____

_____ _____

_____

Doctor's Name _____

NON-PRESCRIBED MEDICINES

My child requires the following non-prescribed medicines:

_____

_____

_____

_____

PRESCRIBED MEDICINES

The Doctor has prescribed (as follows) for my child:

1. Name of drug or medicine to be given.
2. When? (e.g. lunchtime? after food? when wheezy? before exercise?).
3. How much? (e.g. half a teaspoon? 1 tablet? 2 drops?).
4. Route, e.g. by mouth or in each ear.
5. Any special storage instructions?

1. _____
2. _____
3. _____
4 _____
5._____

** Please destroy when the course of medication is complete. Please alert the office that the medication is finished.

(Child's Name)

_____

can administer his/her own medication*/requires supervision to administer his/her own medicine*/requires assistance in administering his/her medicine*.

_____

_____

I request that the treatment be given in accordance with the above information by a named member of the school staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out-of- school activities, as well as on the school premises.

I undertake to supply the school with the drugs and medicines in the original duplicate labelled containers, provided by the Dispensing Chemist.

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

I can be contacted at the following address/telephone during school hours:

Name_____

Contact Address _____

_____ _____

_____ _____

Emergency Telephone Number…….

Signed _____ Date _____

*Delete that which does not apply

THIS FORM SHOULD BE DISCARDED/DESTROYED WHEN THE MEDICATION IS COMPLETED OR CHANGED.

** Please destroy when the course of medication is complete. Please alert the office that the medication is finished.