

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	
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NON PRESCRIBED	
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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: _____