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: _____