

MEDICATION CONSENT FORM (to be filed in Medication Administration Record File)

The school/setting will not give your child any medication unless you complete and sign this form and the Headteacher/Head of Setting has confirmed that school staff have agreed to administer the medication.

DETAILS OF PUPIL

Surname:

Forename (s):

Address: M/F:

..... Date of Birth:

..... Class/Form:

Reason for medication (optional):

CONTACT DETAILS:

Name: Daytime Contact Telephone No:

Relationship to Pupil:

Address:

I understand that the medication must be delivered by a responsible adult to an authorised/appointed person in school and accept that this is a service which the school is not obliged to undertake

Date: Signature (s):

MEDICATION

Name/Type of Medication (as described on the container)

For how long will your child take this medication:

Date dispensed:

FULL DIRECTIONS FOR USE:

Dosage and amount (as per instructions on container):

Method:

Timing:

Special Precautions:

Self-Administration:

a) I would like/would not like (please delete accordingly) my son/daughter to keep his/her asthma inhaler with him/her to use as necessary.

b) I would like/would not like (please delete accordingly) my son/daughter to keep his/her medication on him/her for use as necessary:
(please note that this option excludes Methylphenidate (e.g. Ritalin, Equasym) and applies only to pupils of secondary age)