

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	
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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: _____

SECTION 5

APPROVAL FOR REQUEST YES / NO

HEADTEACHER _____ **DATE** _____

RECORD OF PRESCRIBED AND NON PRESCRIBED MEDICINES ADMINISTERED TO CHILDREN OR SELF ADMINISTERED AS PER PAGE 1

DATE	TIME	MEDICINE & DOSAGE	ADMINISTERED BY	WITNESSED BY

