Thistly Meadow Primary School

ADMINISTRATION OF MEDICINES

Parent/Guardian/Carer CONSENT FORM

To: Head teacher of ……School / Academy

From: Parent/Guardian of……Full Name of Child

DOB: ……..My child has been diagnosed as having:

……(name of condition)

He/she has been considered fit for school but requires the following prescribed medicine to be administered during school hours:

……..(name of medication)

I consent/do not consent for my child to carry out self-administration (delete as appropriate)

Could you please therefore administer the medication as indicated above

…….(dosage) at…..……..(timed).....(intervals) Strength of medication: …….

With effect from……Until advised otherwise.

The medicine should be administered by mouth/in the ear/nasally/other……..

……..(delete as applicable)

I consent/do not consent for my child to carry the medication upon themselves (delete as appropriate)

I undertake to update the school with any changes in medication routine use or dosage.

I undertake to maintain an in date supply of the prescribed medication.

I understand that the school cannot undertake to monitor the use of self-administered medication carried by the child and that the school is not responsible for any loss of/or damage to any medication.

I understand that if I do not allow my child to carry the medication it will be stored by the School and administered by staff with the exception of emergency medication which will be near the child at all times

I understand that staff will be acting in the best interests of ……...(child's name) whilst administering medicines to children.

Signed:……Date:……....

Name of parent (please print)……

Contact Details:

Home……Work:……Mobile:…….....