



PARENTAL CONSENT - ADMINISTRATION OF MEDICINES IN SCHOOL

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT DRUGS ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF OR WHERE A CHILD IS BRINGING MEDICINE INTO SCHOOL WHICH THEY WILL SELF- ADMINISTER.

If you need help to complete this form, please contact the school. Please complete in block letters.

Name of Child :	Date of Birth :
Address :	
Doctor's Name :	

NON-PRESCRIBED MEDICINES : My child requires the following non-prescribed medicines:

.....

.....

.....

PRESCRIBED MEDICINES : The Doctor has prescribed (as follows) for my child:

1. Name of drug or medicine to be given :

2. When? (e.g. lunchtime? after food? when wheezy? before exercise?) :

3. How much? (e.g. half a teaspoon? 1 tablet? 2 drops?) :

4. Route, e.g. by mouth or in each ear :

5. Any special storage instructions? :

.....



(Child's Name)

can administer his/her own medication*/requires supervision to administer his/her own medicine*/requires assistance in administering his/her medicine*.

**delete that which does not apply*

I request that the treatment be given in accordance with the above information by a named member of the school staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out-of- school activities, as well as on the school premises.

I undertake to supply the school with the drugs and medicines in the original duplicate labelled containers, provided by the Dispensing Chemist.

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent and that the school staff may, therefore, need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

I can be contacted at the following address/telephone during school hours:

Name :	Name :
Contact Address :	Contact Address :
Emergency Telephone Number :	Emergency Telephone Number :

Signed : _____
Date : _____

THIS FORM SHOULD BE DISCARDED/DESTROYED WHEN THE MEDICATION IS COMPLETED OR CHANGED.