PARENTAL CONSENT TO ADMINISTER MEDICINES

This document is protected. Click the grey box in each section to complete the form.

Name of pupil/child/young person		DOB	
Group/class/form			
Medical condition or illness			

Medicine

Name/type of medicine (as described on the container)		Expiry date	(y y y y / m m / d d)
		Self-Administration	☐ Yes ☐ No
Dosage and method		Timing	
Special precautions/other instructions			
Are there any side effects that the school/setting needs to know about?			
Procedures to take in an emergency			
Does the medicine link to a specific care plan (e.g. epilepsy care plan, asthma care plan)?			
Does the school have an up-to-date version of this care plan?			

NB: Medicines must be in the original container as dispensed by the pharmacy. A correct supply of the most recently dated medicine is required.

Contact Details

Name	
Daytime telephone no.	
Relationship to pupil/child/ young person	
Address	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to support staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medicine or if the medicine is stopped.

Signature(s) | Date