

Parental Consent to Administer Medicines Form

Staff will not give your child a medicine unless it is in accordance with our Supporting Pupils with Medical Conditions Policy and Procedures, **and** you complete and sign this form.

School/Setting:			
Name of Child:		Class/group:	
Date of Birth:		Sex: male <input type="checkbox"/> female <input type="checkbox"/>	Pronouns: he <input type="checkbox"/> she <input type="checkbox"/> they <input type="checkbox"/>
Date for review to be initiated by:			
Medical diagnosis, condition, or illness			
MEDICINE(S)			
Name/type of medicine(s) (As described on containers)			
Names of <u>controlled drugs</u>?			
Expiry date(s):			
Dosage and method of administration:			
Timing(s):			
Special precautions or other instructions: with food etc.			
Side effects that staff must know about:			
Can the child self-administer?	YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES is supervision required?	YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
Do any medicines need to be carried by the child on their person? YES <input type="checkbox"/> NO <input type="checkbox"/>			
What and where will they keep it?			
Steps to take in an emergency:			

PLEASE NOTE: medicines must be in the original containers as dispensed by the pharmacy.

CONTACT INFORMATION			
Name:			
Relationship to Child:			
Address:	Work Tel. No:		
	Home Tel. No:		
	Mobile Tel. No:		
I understand medicines must be delivered and collected [describe procedure] :			YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
I understand my child must have a working, in-date, and sufficiently full inhaler, clearly labelled with their name, which they will bring with them every day.			YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
I consent to them receiving, in an asthma emergency, salbutamol not prescribed to them.			YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
I understand my child must have the number of working and in-date AAIs that their doctor recommends, clearly labelled with their name, which they bring with them every day.			YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
I consent to my child receiving, in an anaphylaxis emergency, adrenaline not prescribed to them.			YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
The above information is, to the best of my knowledge, accurate at the time of writing and I consent to school/setting staff administering medicine in accordance with the 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.			
Signed:		Date:	