PARENTAL CONSENT FOR ADMINISTRATION OF MEDICINES IN SCHOOL/ON SCHOOL TRIPS

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT DRUGS BE 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: ____________________ **School:** ____________________

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Doctor's name: ____________________

Non-prescribed medicines

My child requires the following non-prescribed medicines:-

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Prescribed medicines

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

	Name of drug or medicine to be given and any special storage instructions:	When? (eg, lunchtime, after food, when wheezy, before exercise):	How much? (eg half a teaspoon, 1 tablet, 2 drops):	Route? eg by mouth or in each ear:
1				
2				
3				
4				

Child's name: ________________________ can administer his/her own medication*/requires supervision to administer his/her own medicine*/requires assistance in administering his/her medicine*

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/centre 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: ____

Signed: _________________________

Contact address: __________________________________

Date: ___________________________

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Contact tel no: ___________________________________

* Delete that which does not apply

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