Parental Consent to Administer Medicine

This school/setting will not give your child 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:		**Gender:**	MALE / FEMALE
Date of Birth:		**Class/Form:**	
Date for review to be initiated by:			
Medical diagnosis, condition or illness			

MEDICINE(S)			
Name/type of medicine(s) (as described on the container)			
Expiry date(s):			
Dosage and method of administration:			
Timing(s):			
Special precautions or other instructions: e.g. with food etc.			
Side effects that the school/ setting must know about:			
Can the child self-administer?	YES / NO	**If YES is supervision required?**	YES / NO
Does any medicine need to be carried by the child on their person, what and where will they keep it?		YES / NO	
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 that I must deliver the medicine personally to: (name the agreed member(s) of staff)			
I understand that 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 NO N/A
I consent to my child receiving, in an asthma emergency, salbutamol which has not been prescribed to them.			YES NO N/A
I understand that my child must have the number of working and in-date AAIs that their medical practitioner has recommended, clearly labelled with their name, which they will bring with them every day.			YES NO N/A
I consent to my child receiving, in an anaphylaxis emergency, adrenaline not prescribed to them.			YES NO N/A
The above information is, to the best of my knowledge, accurate at the time of writing and I consent to 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:**	