Parental Consent to Administer Medicine

This school will not give your child medicines or medical treatments unless it is in accordance with our Supporting Pupils with Medical Conditions Policy and procedures **and** you complete and sign this form. Parents can complete this entire form, but in line with recommendations from child protection Serious Case Reviews, **a relevant medical professional must also sign their agreement** to the administration of medicines and treatments described below. **Please PRINT information clearly and use BLACK INK where possible.**

Name of Child:				**School/Setting:**			
Date of Birth:		**Gender:**	MALE / FEMALE	**Class/Form:**		**Date for review to be initiated by:**	
Medical diagnosis, condition or illness							

MEDICINE(S)					
Name/type of medicine(s) (as described on container)	**Expiry date**	**Dosage and method of administration**	**Timing**	**Special precautions or other instructions** e.g. with food etc.	**Side effects that we need to know about**

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

Can the child self-administer?	YES / NO	**If YES is supervision required?**	YES / NO (if YES, please detail e.g. visual only, guiding hand, measure check only etc.)
Does any medicine need to be carried by the child on their person, what and where will they keep it?		YES / NO (if YES, please give details):	
Procedures to follow in an emergency:			

EMERGENCY CONTACT INFORMATION			
Name:		**Relationship to Child:**	
Address:		**Work Tel. No:**	
		Home Tel. No:	
		Mobile Tel. No:	

Parental Declarations	
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. I consent to my child receiving, in an asthma emergency, salbutamol which has not been prescribed to them.	YES NO N/A 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. I consent to my child receiving, in an anaphylaxis emergency, adrenaline not prescribed to them.	YES NO N/A YES NO N/A
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 medication or if the medicine is stopped.	

Signed:		**Print Name:**		**Date:**	

Medical Practitioner Declaration					
The above information is, to the best of my professional knowledge of this child, accurate. I agree that, in order to adequately support this child at school with their medical condition(s), school staff need to administer or facilitate and/or supervise the self-administration of the medicines or treatments described above.					
Signed:		**Print Name:**		**Date:**	

Professional Relationship to Child:		**Recommended Date of Review/Review Trigger:**	