Consent Form to Administer Medicines on School site and off-site activities

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**School staff will not give your child medication unless this form is completed and signed.**

Dear Head teacher

I request and authorise that my child\* **be given/gives himself/herself** the following medication: (\*delete as appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of child** |  | **Date of birth** |  |
| **Address****Daytime Tel no(s)** |  |
| **Class** |  |
| **Medical Condition or Illness, and reason for medication** |  |
| **Name of medicine:** | **N.B Medicines must be in their original container, and clearly labelled** |
| **Special precautions e.g. take after eating** |  |
| **Are there any side effects that the school needs to know about** |  | **Dose** |  |
| **Time of Dose** |  | **Maximum Dose** (if applicable) |  |
| **Start Date** |  | **Finish Date** |  |

**I confirm that:**

* I have received medical advice stating that it is, or may be in an emergency, necessary to give this medication to my child during the school day and during off-site school activities;
* I agree to collect it at the end of the day/week/half term (delete as appropriate) and replace any expired medication as soon as possible, disposing of any unused medication at the pharmacy;
* This medicine has been given without adverse effect in the past/ I have made the school aware any side effects that my child is likely to experience, and how the school should act if these occur (delete as appropriate);
* The medication is in the original container labelled with the contents, dosage, child’s full name and is within its expiry date; and
* The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy and my child’s Care Plan. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

|  |  |
| --- | --- |
| **Signed (parent/Carer)** |  |
| **Date** |  |
| **Based on the above information the Head Teacher acknowledges that it is, or may be, necessary for your child to be given medication during school hours****Signed (Head teacher)** |  |