PARENTAL CONSENT FOR ADMINISTRATION OF MEDICINES

Cherish, Nurture, Achieve

BECKET PRIMARY SCHOOL WILL NOT GIVE YOUR CHILD MEDICINE UNLESS YOU COMPLETE AND SIGN THIS FORM.

ALL MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY AND ANY INSTRUCTIONS WRITTEN IN ENGLISH.

NAME OF CHILD	
DATE OF BIRTH	
CLASS	
DOCTOR'S NAME	
SURGERY PHONE NUMBER	
NAME & STRENGTH OF MEDICINE	
IS THIS MEDICINE *PRESCRIBED/*NON-PRESCRIBED? (*delete as appropriate)	
DOSE/HOW MUCH?	
ROUTE e.g. by mouth, in the ear	
TIMING e.g. lunchtime, after food, when required	
SIDE EFFECTS?	
ANY KNOWN ALLERGIES?	
***SELF ADMINISTERED/*REQUIRES SUPERVISION TO ADMINISTER/*REQUIRES ASSISTANCE IN ADMINISTERING MEDICATION (*delete as appropriate)**	
EXPIRY DATE	
HOW LONG DOES THIS MEDICINE NEED TO BE GIVEN?	

Parental/Carer signature & up-to-date contact details required over leaf.

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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 activities as well as on the school premises.

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 in line with the school's Medical Conditions Policy. 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: _____

Contact Address: _____

_____

Telephone Number: _____

Signed: _____

Date: _____

I understand that this information will be held securely by school and will not be shared without my consent unless the law and school's policies allow them to do so.
Please tick ✓ ☐

THIS FORM WILL BE DESTROYED WHEN THE MEDICATION IS COMPLETED OR CHANGED.