**ADMINISTRATION OF MEDICINES** 

**PARENTAL/GUARDIAN CONSENT FORM (Form 1) - STRICTLY CONFIDENTIAL**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child’s Name: |  | Year/Class: | | | |
| Address: |  | | | | |
| Date of Birth: |  |  | | | |
| Home Tel No: |  | Work Tel No: | | | |
| GP Surgery |  | GP’s Tel No: | | | |
| Condition/Illness: |  | | | | |
| **Statement:** |  |  |  |  | | |
| **I hereby request that members of staff administer the following medicines as directed below. I understand that I must deliver the medicine personally to the school in the original container as dispensed by the pharmacy and accept that this is a service which the school is not obliged to undertake. I will inform the school/setting immediately, in writing, if there is any change required to the dosage or frequency of the medication required or if the medication is to cease.**  **Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_**  **­­** | | | | | |
| **Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  |  |  |  | |  | |
| **Name of Medicine** | **Dose** | **Prescribed by Medical Practitioner**  **(Yes or No)** | **Frequency &Times for Administration** | | **Date of Completion of Course (if known)** | |
| A |  |  |  | |  | |
| B |  |  |  | |  | |
| C |  |  |  | |  | |
| D |  |  |  | |  | |
| E |  |  |  | |  | |
| Special Instructions/Precautions/Side Effects: | | | | | |
| Emergency Action: | | | | | |
| Other prescribed medicines child takes at home: | | | | | |