CONSENT TO ADMINISTER MEDICINE IN SCHOOL

ABOUT THE PUPIL							
Name of child:							
Date of birth:				Age		Class:	
Please state the medical condition or the reason for this medication. Please be as specific as you can.							
ABOUT THE MEDICINE Please note that unused medicine will be returned to you, if it is still uncollected after a telephone call home, it will be returned to the pharmacy at the end of a half-term.							
Name of medicine *(as described on the container)*							
Medicines must be in the original container as dispensed by the pharmacy							
Expiry date	DD	MM	YY				
Dosage to be given at school							
How is this to be given (Please tick)	By Mouth:		Eye Drops:		Applied as cream		
At what time should we give this?							
Are you giving this medicine at home?	Yes, at ……o'clock				No		
How long should we give this medicine for?							
(Please note that we will not give pain relief medication for longer than 3 days without a medical prescription or note from your Health Visitor or GP)							
Special precautions/other instructions							
Any medical conditions, allergies or side effects we need to know about?							
Can you child self-administer?	Yes				No		
In case of an urgent medical emergency relating to the administering of this medication, we will immediately call an ambulance and then contact parents/carers. In case of a minor issue, we will make contact with parents/carers as soon as we can. If you would like us to follow alternative procedures, please note them here:							
CONTACT DETAILS							
Do you have parental responsibility, special or legal guardianship?	Yes				No		
Name							
Daytime telephone no.			Relationship to child				
Address							

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Spooner Row Primary School to administer medicine in accordance with the school policy. 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.

Signature(s) Date

For School Use

Date medicine provided by parent	DD	MM	YY
Quantity received			

Do not give medicine if review date has passed:

Review Date - 1	DD	MM	YY	Authorised by:
Review Date – 2	DD	MM	YY	Authorised by:
Review Date – 3	DD	MM	YY	Authorised by:
Review Date – 4	DD	MM	YY	Authorised by:

STOP – CHECK!
Do you need to tell the parents that you have given this medicine at school?

Date									
Time given									
Dose given									
Parent contacted?									
Staff initials									

Date									
Time given									
Dose given									
Parent contacted?									
Staff initials									

Date									
Time given									
Dose given									
Parent contacted?									
Staff initials									

Class Notification of Medicine Requirements

Staff Name: ……

Date: …… **Time:** ……

Child Name: …… **Class:** ……

Time Medicine should be given: ……

Date Medicine should be given until: ……

Please ensure the child is prompted of the time they are required to come to the office for their medicine. This can either be written on the board or tear off the clock below to display time on the child's desk.