Parental Consent to Administer Medicines & Record Form

Staff will not give your child a medicine unless it is in accordance with our Supporting Pupils with Medical Conditions Policy and Procedures, **and** you complete and sign this form.

School/Setting:					
Name of Child:				**Class/group:**	
Date of Birth:		**Sex:**	male ☐ female ☐	**Pronouns:**	he ☐ she ☐ they ☐
Date for review to be initiated by:					
Medical diagnosis, condition, or illness					

MEDICINE(S)			
Name/type of medicine(s) (As described on containers)			
Names of controlled drugs?			
Expiry date(s):			
Dosage and method of administration:			
Timing(s):			
Special precautions or other instructions: with food etc.			
Side effects that staff must know about:			
Can the child self-administer?	YES ☐ NO ☐	**If YES is supervision required?**	YES ☐ NO ☐ N/A ☐
Do any medicines need to be carried by the child on their person? YES ☐ NO ☐ **What and where will they keep it?**			
Steps to take in an emergency:			

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

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

I understand medicines must be delivered and collected directed to/from an adult in school:	YES ☐ NO ☐ N/A ☐
I understand 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 them receiving, in an asthma emergency, salbutamol not prescribed to them.	YES ☐ NO ☐ N/A ☐ YES ☐ NO ☐ N/A ☐
I understand my child must have the number of working and in-date AAIs that their doctor recommends, clearly labelled with their name, which they 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 medicine or if the medicine is stopped.	

Signed:		**Date:**	

Date medicine received	Name & Quantity received	Expiry date	Parent Sign	Staff Sign	Date medicine returned	Quantity returned	Parent Sign	Staff Sign

Date:								
Time given:								
Dose given:								
Any reaction?								
Name of staff administering:								
Staff signature.:								
Witness signature.:								
Date:								
Time given:								
Dose given:								
Any reaction?								
Name of staff administering:								
Staff signature.:								
Witness signature.:								