Parental Consent to Administer Medicine

Forename:
Surname:
Date of birth:

Medical diagnosis or condition(s): .....

Please enter details of medication on the reverse of this form.

Declaration:

The information overleaf 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. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.
I accept that this is a service that the school is not obliged to undertake.

Signed: ..... (Parent/Carer) Date: .....

Please print name: .....

For office use only:

Checked prescribed medicines in dispensed packaging: YES/NO
Check non-prescription medicines do not contain ibuprofen or aspirin: YES/NO
Check expiry dates: YES/NO
Entered on monitoring spreadsheet: YES/NO

Signed: ..... Date: .....

Notes:

Name of Medicine	Dosage and Method	Timing	Number/Volume of tablets/medicine received	Any other information