

Consent Form to Administer Medicines

The school/early years setting staff will not give any medication unless this form is completed and signed.

Dear Head Teacher

I request and authorise that my child *be given/gives himself/herself the following medication:
(* delete as appropriate)

Name of child:		Date of Birth	
Address:			
Daytime Tel No(s):			
Infants/Juniors:			
Class:			
Name of Medicine:			
Special precautions e.g. take after eating:			
Are there any side effects that the school needs to know about?			
Time of Dose:		Dose:	
Start Date:		Finish Date:	

This medication has been prescribed for my child by the GP/other appropriate medical professional whom you may contact for verification.

Name of medical professional:	
Contact telephone number:	

I confirm that:

- It is necessary to give this medication during the school day
- I agree to collect it at the end of the **day/week/half term** (delete as appropriate)
- This medicine has been given without adverse effect in the past
- The medication is in the original container indicating the contents, dosage and child's full name and is within its expiry date

Signed: (parent/carer)	
Date:	