MEDICATION CONSENT FORM (to be filed in Medication Administration Record File)

The school/setting will not give your child any medication unless you complete and sign this form and the Headteacher/Head of Setting has confirmed that school staff have agreed to administer the medication.

DETAILS OF PUPIL

Surname: ....

Forename (s): ....

Address: .... M/F: ....

.... Date of Birth: ....

.... Class/Form: ....

Reason for medication (optional): ....

CONTACT DETAILS:

Name: .... Daytime Contact Telephone No: ....

Relationship to Pupil: ....

Address: ....

I understand that the medication must be delivered by a responsible adult to an authorised/appointed person in school and accept that this is a service which the school is not obliged to undertake

Date: .... Signature (s): ....

MEDICATION

Name/Type of Medication (**as described on the container)** ....

For how long will your child take this medication: ....

Date dispensed: ....

FULL DIRECTIONS FOR USE:

Dosage and amount (**as per instructions on container):** ....

Method: ....

Timing: ....

Special Precautions: ....

Self-Administration: ....

a) I would like/would not like (**please delete accordingly**) my son/daughter to keep his/her asthma inhaler with him/her to use as necessary.

I have checked that non-prescription medication does not contain aspirin, and understand the risk of administering aspirin to children aged Under 16 years.

Parent/Carer Name ________________________________ Signature ______________________________