

## 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.

<b>School/Setting:</b>			
<b>Name of Child:</b>		<b>Class/group:</b>	
<b>Date of Birth:</b>		<b>Sex:</b> male <input type="checkbox"/> female <input type="checkbox"/>	<b>Pronouns:</b> he <input type="checkbox"/> she <input type="checkbox"/> they <input type="checkbox"/>
<b>Date for review to be initiated by:</b>			
<b>Medical diagnosis, condition, or illness</b>			
<b>MEDICINE(S)</b>			
<b>Name/type of medicine(s)</b> (As described on containers)			
<b>Names of <u>controlled drugs</u>?</b>			
<b>Expiry date(s):</b>			
<b>Dosage and method of administration:</b>			
<b>Timing(s):</b>			
<b>Special precautions or other instructions:</b> with food etc.			
<b>Side effects that staff must know about:</b>			
<b>Can the child self-administer?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>If YES is supervision required?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
<b>Do any medicines need to be carried by the child on their person?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>What and where will they keep it?</b>			
<b>Steps to take in an emergency:</b>			

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

<b>CONTACT INFORMATION</b>			
<b>Name:</b>			
<b>Relationship to Child:</b>			
<b>Address:</b>	<b>Work Tel. No:</b>		
	<b>Home Tel. No:</b>		
	<b>Mobile Tel. No:</b>		
I understand medicines must be delivered and collected by a responsible adult over 16 years old		YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>	
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.		YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>	
I consent to them receiving, in an asthma emergency, salbutamol not prescribed to them.		YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>	
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.		YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>	
I consent to my child receiving, in an anaphylaxis emergency, adrenaline not prescribed to them.		YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>	
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.			
<b>Signed:</b>		<b>Date:</b>	

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