CONSENT FORM FOR THE ADMINISTRATION OF MEDICINES

The school will not give a pupil medicine unless a parent/carer fully completes and signs this form, and the Headteacher has agreed that school staff can administer the medicine. They will not administer medication if it is dose frequencies such that it can be taken out of school hours ie 3 times per 24 hours. Medicines MUST be in the original container as dispensed by the Pharmacy.

Pupil Name ----------

Year group ----------

Date of Birth ----------

Medical condition or illness: ----------

MEDICINE:

Name of medicine (as described on the container): ----------

Expiry date ----------

Dosage and method ----------

Times to be administered ----------

Days on which to be administered ----------

Special instructions/precautions ----------

Side effects the school needs to be aware of ----------

To be self-administered? Yes/No (please circle)

Does the medication need to be administered by Everlanders (After-school care) staff? Yes/No (please circle)

CONTACT DETAILS:

Parent/Carer name (please print clearly) ----------

Relationship to pupil ----------

Contact phone number/s ----------

I agree to personally delivering the medicine to the school office

Signature ---------- Date ----------

FOR SCHOOL USE ONLY:

Following details to be recorded when medicine administered

Date ----------	Time ----------	Dosage ----------	Staff name ----------
Date ----------	Time ----------	Dosage ----------	Staff name ----------
Date ----------	Time ----------	Dosage ----------	Staff name ----------
Date ----------	Time ----------	Dosage ----------	Staff name ----------
Date ----------	Time ----------	Dosage ----------	Staff name ----------
Date ----------	Time ----------	Dosage ----------	Staff name ----------