CONSENT FORM FOR THE ADMINISTRATION OF MEDICATION

Name…… Year Group……

Requires the following dose of medication to be administered within school.

Times of day to be given	Dosage	Name of medicine/drug and strength	Method of administration

I give my consent for a member of staff to administer the above medicine/drug. I understand that the same member of staff may not be available at all times and the medicine/drug may be administered by a different member of staff.

I undertake to deliver the correct medication (only GP prescribed) to the school office in the original child-proof container/bottle and spoon, if necessary, which will be administered in accordance with my instructions above. The medication will always be kept in a safe place.

I acknowledge that any staff involved in the administering of medication in school are not qualified medical practitioners nor holding themselves to be a qualified medical practitioner.

I understand that the staff in school will take responsible care in all the administration of medicines in school and will endeavour to respond appropriately in all circumstances should emergency treatment be required.

Signed…… Parent/Carer

Date……..