Newton Burgoland Primary School - **Medicine Consent Form**

VOLUNTARY ADMINISTRATION OF MEDICINES

Parent/Guardian/Carer CONSENT FORM

Child's name and class	
Child's date of birth	
My child has been diagnosed as having *(condition)*	

He/she is considered fit for school but requires the following medicine to be given during school hours

Name of medicine	Dose required

Time/s of dose (lunchtime is preferred please) We do not administer at the beginning or end of school unless exceptional circumstances	
With effect from [start date]	
Until [end date]	

The medicine should be taken by *(mouth, nose, in the ear, other: please provide details as appropriate)* ** *Please note that we do not administer medicine to eyes, nose or ears – your child needs to be capable of administering themselves, under adult supervision*

I consent/do not consent for my child to take the medicine by him/herself and therefore kindly request/do not request that you arrange for the administration of the above medicine as indicated. *(Please delete as appropriate)*

This medicine needs to be kept in a fridge. YES NO *(Please delete/circle as appropriate)*

By signing this form I confirm the following statements:

- That my child has taken this medicine or at least two doses of this medicine before and has not suffered any adverse reactions.
- That I will update the school with any change in medication routine use or dosage
- That I undertake to maintain an in-date supply of the medication
- That I understand the school cannot undertake to monitor the use of self-administered medication carried by my child and that the school is not responsible for any loss of/or damage to any medication
- That I understand the school will keep a record of medicine given and will provide a copy of this on request.
- That I understand staff will be acting in the best interests of my child whilst administering medication and that it is carried out voluntarily.
- That I will inform school if this medicine has been administered at home before school and at what time.

Signed	
Name (please print)	
Contact details	
Date	
Staff member signature	
Name (please print)	
Date	

PARENTS/CARERS PLEASE COMPLETE BOTH SIDES OF THIS FORM

MEDICINE ADMINISTRATION PROCEDURES

PARENT/CARER TO COMPLETE THE FOLLOWING. Please note that we do not administer medicine to eyes, nose or ears – your child will need to be able to administer themselves under adult supervision.

CHILDS NAME.....

DOSAGE..... Medicine to be stored in Fridge YES/NO

TIME TO ADMINISTER.....

MEDICINE CLEARLY LABELED WITH CHILDS NAME YES/NO – IF NO - PLEASE COMPLETE A LABEL OR LABEL MEDICINE CLEARLY

IF MEDICINE HAS BEEN ADMINISTERED BEFORE SCHOOL PLEASE COMPLETE BELOW

DATE	TIME	ADMINISTERING STAFF SIGNATURE

OFFICE INFORMATION - MEDICINE ADMINISTRATION PROCEDURES

- Parent/Guardian to complete both sides of VOLUNTARY ADMINISTRATION OF MEDICINES
- All medicines must be labelled - Parent/Guardian to complete label
- Check that an appropriate method of administration is provided e.g. medicine spoon
- Tablets/medicine not requiring refrigeration must be labelled and placed in the "Administration of Medicine" box on shelf in office or mobile classroom
- Medicine needing refrigeration must be kept in kitchen or mobile fridge
- Completed and signed request form to be kept in Administration of Medicine box in office or Mobile
- Staff to sign form when medicine administered