PARENTAL CONSENT FOR PUPIL TO BE GIVEN MEDICATION IN SCHOOL (prescribed or other)

**One consent form per medication**

|  |  |
| --- | --- |
| Name of child |  |
| Date of birth |  |
| Form |  |
| Medical condition or illness |  |
| **All medications must be in the original packaging and container.****If dispensed by a pharmacy, the prescription label must be visible on the packet / container.****We will not be able to accept loose tablets or blister packs.** |
| Name / type of medication*(as described on the container)* |  |
| Dosage  |  |
| Timing(s) |  |
| How long should medication be given |  |
| Special precautions / other instructions i.e storage |  |
| Are there any side effects that the school needs to know about? |  |
| Expiry date of medication |  |
| Amount of medication provided |  |
| **I agree that Matron gives my child the above Medication** |
| Print name (Parent / Guardian) |  |
| Signature (Parent / Guardian) |  |
| Relationship to child |  |
| Daytime telephone no. |  |

**All medication is to be delivered and collected by a parent/guardian to Reception**