

STENSON FIELDS PRIMARY COMMUNITY SCHOOL

Headteacher: Mrs J Sadler BEd Hons NPQH

Caring, Achieving, Respecting, Enjoying, Supporting



Parental Consent for Schools/Setting to Administer Medicine

The school/Setting will not give your child medicine unless you complete and sign this form, and has a policy that staff can administer medicine, and staff consent to do this.

Note: Medicines must be in the original container as dispensed by the pharmacy

Name of School/Setting

STENSON FIELDS PRIMARY
COMMUNITY SCHOOL

Date

Day
/ Month / Year

Childs name

Date of birth

Day / Month / Year

Group/Class/Form

Medical condition or illness

Medicine

Name/type of medicine/strength

(as described on the container)

Date dispensed

Day / Month / Year

Expiry date

Day / Month / Year

Agreed review date to be initiated by

(name of member of staff)

Dosage and method

Timing – when to be given

Special precautions

Any other instructions

Number of tablets/quantity to be given to
School/Setting

Are there any side effects that the
School/Setting needs to know about?

Self administration

Procedures to take in an emergency

Contact Details – First Contact

Name

Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Contact Details – Second Contact

Name

Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Name and phone number of G.P.

The above information is, to be the best of my knowledge, accurate at the time of writing and I give consent to School/Setting staff administering medicine in accordance with the School/Setting policy. I will inform the School/Setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I accept that this is a service that the School/Setting is not obliged to undertake.
I understand that I must notify the School/Setting of any changes in writing

Date _____ Signature(s) _____

Parent's signature _____

Print name _____

Date _____

If more than one medicine is to be given a separate form should be completed for each one.

For School/Setting Use

Reviewed by	Date	Signature	Print Name

To be reviewed annually or if dose changes.

