



Parent/Carer

Consent to Dispense Medication in School

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT MEDICATION (TABLETS, LIQUIDS & CREAMS) IS ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF.

CHILD'S NAME:..... AGE: CLASS.....

DOCTOR'S NAME: TEL NO:

What illness is your child suffering from?

What symptoms does your child have?

.....

Has your child seen the doctor? Yes / No

Has the medication been prescribed by the doctor? Yes / No

Name and strength of medication:

Dose to be given (how much):

When to be given:

Any other instructions (for example in an emergency):

.....

Start date: End date:

Quantity given to school:

MEDICATION MUST BE IN THE ORIGINAL CONTAINER/PACKAGING, AS DISPENSED BY THE DOCTOR/CHEMIST WITH YOUR CHILD'S NAME AND CLEAR INSTRUCTIONS ON IT.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff volunteering to administer medicine to do so in accordance with the instructions completed above. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Parent/Carer's Signature:..... Date:.....

Print Name:.....

Contact Numbers:

IF MORE THAN ONE MEDICATION IS TO BE GIVEN A SEPARATE FORM SHOULD BE COMPLETED FOR EACH.