Consent Form for the Administration of Prescribed and Over the Counter Medicine in School

Prescribed Medication

Name of child: _____ Class: _____

Condition for which medicine has been prescribed: _____

Name of prescribed medicine
1. _____Dosage: _____

2. _____Dosage: _____
Administration instructions:

_____

Signed: _____ (Parent/Guardian)

Date: _____

ALL MEDICINES MUST BE PRESCRIBED BY A DOCTOR AND KEPT IN THEIR ORIGINAL PACKAGING.

Over The Counter Medication (Only in exceptional circumstances)

Name of child: _____ Class: _____

Condition for which medicine is required: _____

Name of Over the Counter medicine:
1. _____Dosage: _____

2. _____Dosage: _____
Administration instructions:

_____

Signed: _____ (Parent/Guardian)

Date: _____

Disclaimer

I _____(parent/carer), can confirm that the above Over the Counter medication has been previously administered without adverse effect in the past. Staff can only administer this medication for up to a maximum of 48hours from the above date. If symptoms persist I will seek further advice from a medical professional.

Signed: _____ (Parent/Guardian)

Date: _____

5 DIMENSIONS TRUST

Priory Rise School