**Consent Form to Administer Medicines to Pupil**

**Please complete this form to authorise school staff to administer listed medication to your child**

Dear Head of School

I request and authorise that my child is given/gives him/herself the following medication:

|  |  |
| --- | --- |
| Name  |  |
| Date of birth |  | Class |  |
| Address |  |
| Name of medicine: |  |
| Does the medication need to be refrigerated? | Yes | No  |  |
| Dose |  | Time of dose |  |
| Start date |  | Finish date |  |

|  |
| --- |
| This medication has been prescribed by a GP/other appropriate medical professional? |
| Yes | No |

I confirm that:

* It is necessary to give this medication during the school day.
* The medication is in the original container indicating the contents, dosage and child’s full name and is within its expiry date.

|  |  |
| --- | --- |
| Signed parent/carer |  |
| Date  |  |
| Name of child |  |
| Name of medication |  |
| **Date** | **Time** | **Dose** | **Signature and name** | **Comments** |
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