New Siblands School
"Achievement, Belonging, Celebration"

Consent to give controlled medication in school

Pupil's Details
Full Name:

Date of birth:

Allergies:

Pupil's Photograph to assist with administering medicine in school.

Emergency contact details of parent/carer
Name:
Relationship to pupil:

Daytime contact telephone numbers:

Medicine to be given in School

Name of Medicine (as described on container):

Strength and form of Medicine: Dose in mg:

Method of administration: Time/frequency to be given:

Date of opening: Expiry date:

Special instructions (e.g. with food, or after food, whether medicine needs to be stored in the fridge, does it need dissolving, crushing, use within certain number of days after opening etc?)

I give my consent for an appropriately trained member of staff to administer the above medication on my behalf during school time. (To be completed by the person with parental responsibility)

Signature: Print Name:
Date:

In the event of an adverse reaction to the medication, or pupils vomiting or spitting out the medicine, the dose will not be repeated, and you will be informed immediately.

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Record of medicine Administered

Pupils's Name: Date of birth:

Name of Medicine Dose in mg:

Date	Number of tablets in stock	Number of tablets administered	Number of tablets remaining	Time Given	Signature