

Date:





<b>Consent to Give Medication</b>	in School	Child's Photograph
Child's Details: Child's Full Name:		
Address:		
Home telephone No:		We collect this data to
Date of birth:	Allergies:	assist with administering medicine in school
Contact details of parent / carer. Name:		
Relationship to Pupil:		
Daytime telephone numbers:		
Address:		
Medicines to be given in School:  Name of Medicine (as described	on container):	
Strength and form of Medicine:	,	Dose in mg:
Method of administration:		Time to be given:
Medicine is long term / short cor (Please delete as appropriate)	urse. If short cour	se when does course end?
Special instructions (e.g. with food it need dissolving or crushing? etc.):	I, or after food, whether medic	sine needs to be stored in the fridge, does
(declaration below to be completed by a polygon of the latest and the latest administer the above medication or	health worker who has r	eceived appropriate training to
Signature:	Print	Name:



Child's Name:





Date of birth:

Parents / carers should note that they will be contacted if their child shows any adverse reaction to medicines given in school. If their child vomits or spits out medicines then the dose will not be repeated, and parents / carers will be informed.

## Record of Medicine Administered

Name of N	Medicine:		Dose in mg:  Reason for Giving Medicine
Date:	Time:	Signature:	Reason for Giving Medicine
	<b>+</b>		





