ST. PETER'S CHURCH OF ENGLAND PRIMARY SCHOOL

MEDICATION CONSENT FORM

PUPILS DETAILS

NAME ……………………………………………………………………………………..

DATE OF BIRTH ……………………………… CLASS ……………….............

NAME OF PARENT /CARER …………………………………………….............

HOME TELEPHONE NO ……………………………………………..................

WORK TELEPHONE NO …………………………………………….................

MOBILE TELEPHONE NO ………………………………………….................

MEDICAL CONDITION OR ILLNESS …………………………………………

NAME OF MEDICINE …………………………………………………………

EXPIRY DATE ……………………………………………………………….

DOSAGE ……………………………………………………………………..

TIME TO BE GIVEN…………………………………………………………

SPECIAL INSTRUCTIONS …………………………………………………..

SIDE EFFECTS ……………………………………………………………...

SELF ADMINISTRATION- Y/N

PROCEDURES TO TAKE IN AN EMERGENCY ………………………………

ARE YOU HAPPY FOR YOUR CHILD TO COLLECT THEIR MEDICINE AT THE END OF THE SCHOOL DAY- Y/N

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

Signature …………………………….. Date ……………………………

For office use only:
Date for review to be initiated by ………………………………………

DATE	TIME GIVEN	DOSE GIVEN	NAME OF MEMBER OF STAFF	STAFF INITIALS