

Greatham Primary School - Administration of Prescribed Medicines Consent Form

School name: Greatham Primary School

Child's name: _____

Child's date of birth: _____

Child's address: _____

Parents' home telephone no: _____

Parents' work telephone no: _____

Parents' mobile telephone no: _____

Name of GP: _____

GP telephone no: _____

Please tick the appropriate box:

My child will be responsible for the self-administration of medicines as directed below

I agree to members of staff administrating medicines to my child as directed below or in the case of an emergency, as staff may consider necessary

I recognise that school staff are not medically qualified

Name of medicine	Dose/Method	Frequency	Completion date of course (if known)	Expiry date of medicine

Note: Medicines must be in the original container as dispensed by the pharmacy

Special instructions: _____
 (incl. potential side effects & procedures to take in an emergency) _____

Allergies: _____

Other prescribed medicines: _____

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

Signed (parent/carer): _____ Date: _____

