Appendix 1

Woolaston Primary School

Parental consent for the Administering of Prescribed Medicine or Treatment to Children and Record of Administration of Prescribed Medicine to Children

For the School Office
The school will not give your child the prescribed medicine unless you complete and sign this part of the form.

Child's Name_____

Date of Birth_____

Class_____

Name and strength of Medicine_____

Date of dispensing_____

Expiry date_____

Method of administration (e.g.oral)_____

How much to give (i.e. dose to be given)_____

When to be given/frequency of administration_____

Duration of treatment_____

Any other instructions_____

Storage instructions_____

Are there any side-effects the school needs to know?_____

Please include the medicines Patient Information Leaflet.
Note: Medicines must be in the original container as dispensed by the pharmacy. The above directions must be consistent with the instructions of the prescriber as printed on the original container.
Daytime phone number of parent or adult contact_____
Name and phone number of GP_____
Delivery of medicine should be made to the school by the parent or by another adult acting at the request of a parent.
The above information is, to the best of my/our knowledge, accurate at the time of writing and I/We give consent to school staff administering medicine in accordance with the school

policy. I/we agree that the treatment may be administered by persons without medical qualifications. I/We 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. I/We acknowledge that the school cannot guarantee compliance with the treatment directions should unforeseen circumstances arise and that the school will not be liable for any shortcomings in treatment.

Parent's signature_____ Print name_____

Date_____

If more than one medicine is to be given a separate form should be completed for each one. Please return the completed form to the school office.
Below is a copy of the Record of Administration of Prescribed Medicine to a child (to be completed by the staff member administering the medication).
It is the responsibility of the staff member administering the prescribed medication to ensure all details completed by the parent overleaf are consistent with the instructions of the prescriber as printed on the original container, prior to administration of the medicine.

Date	Time	Name of medicine	Dose Given	Member of staff	Witness

Parent signature_____Date_____

This form should remain at school however a copy may be supplied to the parent/guardian at their request.