Technical learning with local professional partners

QEStudio

PARENTAL CONSENT FOR THE SCHOOL TO ADMINISTER MEDICINES

This form relates to the administration of prescription medication that is prescribed by a doctor and the administration of non-prescription medication i.e. cough syrup, vitamins and paracetamol.

Student		**Date of Birth**		**Form**	

Medication	
Name of Medication	
Reason for Medication	
Is this a prescribed medicine?	
Name of Prescriber	
Date Dispensed	
Expiry Date	
Dosage , Timing & Duration	
Any other information/instructions	

Contact Details			
Name			
Address			
Daytime Tel no		**Mobile**	
Email Address			
Relationship to Student			

Consent			
I consent to the school administering medicine in accordance with this information, which is to the best of my knowledge accurate at this date. In the case of non prescription medication I can confirm that this has been administered to my child without adverse effect in the past. I understand that aspirin containing medicine should not be given to under 16's unless prescribed by a doctor. I agree to supply the school with the medicines in their original containers and to inform the school immediately if any of the above information changes or the medication is stopped.			
Signature		**Date**	
Name			

Technical learning with local professional partners

QEStudio

RECORD OF MEDICINE ADMINISTERED

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	

Date & Time	
Dose	
Staff initials	