**MARKEATON PRIMARY SCHOOL**
BROMLEY STREET
**DERBY DE22 1HL**

Headteacher: Mr. I Johnson Telephone: 01332 347374
School/Medical/Medicine Parental Consent

**PARENTAL CONSENT - ADMINISTRATION OF MEDICINES IN SCHOOL**

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT DRUGS BE ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF (medicine prescribed by Doctor only)!

If you need help to complete this form, please contact the School Office.
**Please complete in block letters.**

Name of Child …… Date of Birth ……..

Teacher/Class ……..

The Doctor has prescribed as follows for my child:

| **Name of drug?** | **When?** (e.g. lunchtime/after food/when wheezy) | **Duration?** (e.g. 2 days/until medication finished) | **How much?** (e.g. 5ml/1 tablet/2 drops) | **Route?** (e.g. by mouth/in each ear) | **Any special storage instructions?** (e.g. keep cool/room temperature) |
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- I request that the treatment be given in accordance with the above information by a named member of the school staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits as well as on the school premises.
- I undertake to supply the school with the drugs and medicines in the original packaging with my child's name and date of birth printed by the Dispensing Chemist.
- I accept that, whilst my child is in the care of the school, the school staff stand in the position of parent and that the school staff may therefore need to arrange any medical aid considered necessary in any emergency. If emergency aid is required, I will be told of any such action as soon as possible.

I can be contacted on the following telephone numbers:

**Contact 1** Name …… Relationship to child ……

Contact telephone nos: …… (home) …… (work) …… (mobile)

**Contact 2** Name …… Relationship to child ……

Contact telephone nos: …… (home) …… (work) …… (mobile)

Contact telephone nos: …… (home) …… (work) …… (mobile)

Signed …… Date ……

Parent Name ……

**Child's Name:** **Class:**

| *DATE* | TIME LAST ADMINISTERED BY PARENT | TIME ADMINISTERED BY SCHOOL | INITIALS OF PERSON ADMINISTERING MEDICINE | WITNESS' INTIALS | INITIALS OF ADULT COLLECTING MEDICINE FROM SCHOOL OFFICE |
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