MARKEATON PRIMARY SCHOOL
BROMLEY STREET
DERBY DE22 1HL

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

Telephone: 01332 347374

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.

Name of Child …… Date of Birth ……..

Teacher/Class ……..

The Doctor has prescribed as follows for my child *(please complete one form for every medication):*

Medical Condition?					
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)	**Storage instructions?** (e.g. fridge/room temperature)
Expiry Date: ……					
My child (named above) is able to administer their own medication under supervision YES/NO?					

- 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.

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)

If this is an ongoing medication, a new form does not need to be completed every time a new bottle/pack is received HOWEVER careful attention must be paid to checking the following remains the same: PERSON'S NAME, NAME OF MEDICATION and DOSE (how much). IF ANY OF THESE DETAILS CHANGE A NEW FORM MUST BE COMPLETED BY THE PARENT/CARER.

Expiry Date	**Parent/Carer's Signature**	**Date New Medication received**

SIGNED …… DATE ……

PRINT NAME ……

Child's Name: **Class:**

DATE	TIME LAST ADMINISTERED BY PARENT	TIME ADMINISTERED BY SCHOOL	INITIALS OF PERSON ADMINISTERING MEDICINE	WITNESS' INTIALS	DOSAGE ADMINISTERED (1 tablet/5ml etc.)	INITIALS OF ADULT COLLECTING MEDICINE FROM SCHOOL OFFICE

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