THURGOLAND
CHURCH OF ENGLAND PRIMARY SCHOOL
LEARNING TOGETHER IN FAITH & JOY

AM1

PARENTAL CONSENT FORM FOR THE ADMINISTRATION OF MEDICINES

SECTION 1

PUPIL NAME: _____

CLASS NO/TEACHER: _____

DATE OF REQUEST: _____

SECTION 2

PARENT CONTACT NUMBER: _____

DAY TIME EMERGENCY CONTACT NUMBER: _____

PARENT(S) OR CARER(S) NAME: _____

SECTION 3

NAME OF MEDICATION: _____

IS THIS MEDICINE:

PRESCRIBED		NON-PRESCRIBED	

DOES THE MEDICATION NEED TO BE REFRIDGERATED? YES / NO

DOES THE MEDICATION NEED TO BE RETURNED HOME EACH DAY? YES / NO

CONDITION OR ILLNESS EG WATER INFECTION:_____

DATE PRESCRIBED: _____

DETAILS OF DOSAGE EG. 5ML:_____

TIME(S) MEDICATION TO BE GIVEN: _____

DATE COURSE OF MEDICATION FINISHES: _____

SECTION 4

DECLARATION BY THE PARENT/LEGAL GUARDIAN

I consent to my child being administered the prescribed medicine in accordance with the information above. I understand that it is the School Policy not to force children to take their medicine if they refuse to do so. In the event of this occurring, the nominated contact will be notified.

I understand that the LEA, Governing Body of the school and the staff cannot accept responsibility for any adverse reaction my child may suffer as a consequence of being administered the prescribed medication at my request.

Signed: _____

Relationship to Child: _____

SECTION 5

APPROVAL FOR REQUEST YES / NO

Headteacher/Authorised Person_____ Date: _____