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| FOI Status: Public | <b>CHILDREN AND YOUNGER<br/>ADULTS DEPARTMENT</b> | Version:<br>Review Date: |
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## **Form 2 - Parental Consent for Schools/Setting to Administer Medicine**

The school/Setting will not give your child medicine unless you complete and sign this form, and has a policy that staff can administer medicine, and staff consent to do this.

**Note: Medicines must be in the original container as dispensed by the pharmacy**

|                              |                                                 |
|------------------------------|-------------------------------------------------|
| Name of School/Setting       | <input type="text"/>                            |
| Date                         | <input type="text" value="Day / Month / Year"/> |
| Childs name                  | <input type="text"/>                            |
| Date of birth                | <input type="text" value="Day / Month / Year"/> |
| Group/Class/Form             | <input type="text"/>                            |
| Medical condition or illness | <input type="text"/>                            |
|                              | <input type="text"/>                            |
|                              | <input type="text"/>                            |
|                              | <input type="text"/>                            |

### **Medicine**

|                                                                            |                                                               |
|----------------------------------------------------------------------------|---------------------------------------------------------------|
| Name/type of medicine/strength<br>(as described on the container)          | <input type="text"/>                                          |
|                                                                            | <input type="text"/>                                          |
| Date dispensed                                                             | <input type="text" value="Day / Month / Year"/>               |
| Expiry date                                                                | <input type="text" value="Day / Month / Year"/>               |
| Agreed review date to be initiated by<br>(name of member of staff)         | <input type="text"/>                                          |
| Dosage and method                                                          | <input type="text"/>                                          |
| Timing – when to be given                                                  | <input type="text"/>                                          |
| Special precautions                                                        | <input type="text"/>                                          |
| Any other instructions                                                     | <input type="text"/>                                          |
| Number of tablets/quantity to be given to<br>School/Setting                | <input type="text"/>                                          |
| Are there any side effects that the<br>School/Setting needs to know about? | <input type="text"/>                                          |
| Self administration                                                        | <input type="text" value="Yes / No (delete as appropriate)"/> |
| Procedures to take in an emergency                                         | <input type="text"/>                                          |

### **Contact Details – First Contact**

|      |                      |
|------|----------------------|
| Name | <input type="text"/> |
|      | <input type="text"/> |

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Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

**Contact Details – Second Contact**

Name

Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Name and phone number of G.P.

The above information is, to be the best of my knowledge, accurate at the time of writing and I give consent to School/Setting staff administering medicine in accordance with the School/Setting policy. I will inform the School/Setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I accept that this is a service that the School/Setting is not obliged to undertake.  
I understand that I must notify the School/Setting of any changes in writing

Date \_\_\_\_\_ Signature(s) \_\_\_\_\_

Parent's signature \_\_\_\_\_

Print name \_\_\_\_\_

Date \_\_\_\_\_

If more than one medicine is to be given a separate form should be completed for each one.

For School/Setting Use

| Reviewed by | Date | Signature | Print Name |
|-------------|------|-----------|------------|
|             |      |           |            |
|             |      |           |            |
|             |      |           |            |
|             |      |           |            |
|             |      |           |            |

**To be reviewed annually or if dose changes**