

Appendix 2

Medication Consent Form

Pupil Name		Class	
Medical Condition or Illness			
Name of Medicine			
Reason for the medication			
Expiry Date of medicine		Dosage	
Self Administer ?	Yes No	Timing	
End date of medication			
Notes on Medicine (precautions / side effects)			

I understand that I am responsible for providing the school with a replacement of the medication if it passes its expiration date and is still required by my child (please ☐ k)

The above information is, to 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.

Name of parent (Print)		Signature of parent	
Relationship to child			
Staff member receiving this form		Date	

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

Medicine Administration Record

Pupil Name		Year Group	
Medication		Date Started	
Dosage and Frequency			

Date	Time	Dosage	Name and signature of staff that has administrated medication	Name and signature of staff who witnessed the administration