PARENTAL CONSENT FORM FOR THE ADMINISTRATION OF MEDICINES

Pupil Name		
Class / Teacher		
Date of Request		
Parent Name		
Parent Contact Number		
Name of Medication		
Is this medicine	Prescribed	Non-Prescribed
Condition		
Date Prescribed		
Details of dosage		
Time / Frequency of dosage		
Date course finishes		

Declaration by the parent / legal guardian

I consent to my child being administered the prescribed / non 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 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: _____ Date: _____

Relationship to child: _____

Approval for Request

YES	NO
Name -	**Signature -**

DATE	TIME	PUPIL	MEDICINE / DOSAGE	CONDITION	ADMINISTERED BY