Consent for to Administer Medicines

The school/early years setting staff will not give any medication unless this form is completed and signed.

Dear Head teacher/setting lead or manager

I request and authorise that my child be given/gives himself/herself the following medication.

Name of child		Date of Birth	
Address Daytime Tel No			
Name of School			
Class			
Name of Medicine			
Special precautions e.g. take after eating			
Are there any side effects that the school needs to know about?			
Start Date		Finish Date	
Time of dose		Dose	

This medication has been prescribed for my child by the G.P/other appropriate medical professional whom you may contact for verification.

Name of medical professional	
Contact telephone number	

I confirm that;

- It is necessary to give this medication during the school day.
- I agree to collect it at the end of the day/week/half term (delete as appropriate)
- This medicine has been given without adverse effects in the past.
- The medication is in the original container indicating the contents, dose and child's full name and is within its expiry date.

Signed (parent/carer)	
Date	

Administration Record

Name of Child	
Date of Birth	
Name of medication	
Expiry date	

Date	Time	Dose	Signature and name	Comments