

**ASHCOMBE PRIMARY SCHOOL
CONSENT FOR SCHOOL TO ADMINISTER MEDICATION**

*Form to be completed by parents if they wish the school to administer medication
The school will not give your child medicine unless you complete and sign this form.*



DETAILS OF STUDENT

| | | | |
|----------------------------|--|----------------------|--|
| Name | | Male / Female | |
| Date of Birth | | Class | |
| Address | | | |
| Illness / Condition | | | |

MEDICATION

| | | | |
|---|------------------|----------------------|--|
| Medication (as described on the container and in original packaging) | | Expiry Date | |
| Quantity received | | Date Received | |
| What is the dosage, timings & duration | Dosage: | | Self-administer? yes no |
| | Timings: | | |
| | Duration: | | |

| | |
|---|--|
| Any side effects? Special precautions? | |
|---|--|

| | |
|--|--|
| Procedure to take in an emergency | |
|--|--|

EMERGENCY CONTACT DETAILS

| | | | |
|----------------|--|-----------------------------------|--|
| Name | | Relationship to Pupil | |
| Address | | Emergency telephone number | |

The above information is, to the best of my knowledge accurate at the time of writing and I give consent to the school staff to administer the medication in accordance with the school medication policy. I understand that I must deliver the medication personally to the school office and accept that this is a service that the school is not obliged to undertake.

I will inform the school office immediately if there is any change to the information on this form or if the medication is stopped.

| | | | |
|------------------------------|--|------------------|--|
| Name | | Signature | |
| Relationship to pupil | | Date | |

