Consent Form 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: (**\***delete as appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of child** |  | **Date of Birth** |  |
| **Address****Daytime Tel no(s)** |  |
| **School/setting** |  |
| **Class (where applicable)** |  |
| **Name of Medicine:** |  |
| **Special precautions e.g. take after eating** |  |
| **Are there any side effects that the school/setting needs to know about?** |  |
| **Time of Dose** |  | **Dose** |  |
| **Start Date** |  | **Finish Date** |  |

This medication has been prescribed for my child by the GP/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/setting 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 effect in the past.
* The medication is in the original container indicating the contents, dosage and child’s full name and is within its expiry date.

|  |  |
| --- | --- |
| **Signed (parent/carer)** |  |
| **Date** |  |