

STRICTLY CONFIDENTIAL



Parental Consent for School to Administer Medication/Treatment

The school will not give your child medicine unless you complete and sign this form.

Details of Pupil

Name _____ Class _____

Condition or Illness: _____

Details of Medication

Name of Medication	Prescribed by GP/Specialist or Non- Prescribed (P or NP)	Dose	Frequency /Times	Date of Completion of Course (if known)
	P NP			
	P NP			
	P NP			
Special Instructions / Precautions / Side Effects				
Allergies				
Other prescribed medicines child takes at home				

- I hereby request that members of staff administer the following medicines as directed below.
- I understand that I must deliver the medicine personally to the School Office in the original container as dispensed by the pharmacy.
- I accept that this is a service that the school is not obliged to undertake.
- I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Signed _____

Date _____

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