Killamarsh Infant and Nursery School

PARENTAL CONSENT FORM

ADMINISTRATION OF MEDICINES IN SCHOOL

To be completed by the parent/guardian of any child requesting drugs to be administered by or under the supervision of school staff or where a child is bringing medicine into school which they will self administer.

PLEASE COMPLETE IN BLOCK LETTERS

Name of Child ……

Date of Birth : …….. Date of Request ……..

Address : ……..

……

Prescribed Medicine

Name of Medicine : _____

When to be given :

Normally 11.45 am) _____

How much : _____

Any special instructions _____

_____

For how long medicine required : _____

I request that the treatment be given in accordance with the above information by a member of the school staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during

Educational visits and other out of school activities, as well as on the School premises.

I undertake to supply the school with the drugs and medicines in the original labelled containers provided by the

Dispensing Chemist.

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent and that the school staff may, therefore, need to arrange any medical aid considered in an emergency, but I will be informed of any action as soon as possible.

I can be contacted at the following address / telephone number during school hours.

Name : _____ Signed : _____

Address (if different) Telephone Number :