



Consent Form to Administer Medicines



Newtown C.E. Primary School's staff will not give any medication unless this form is completed and signed by the child's parent/carers

I request and authorise that my child *be given / gives himself/herself the following medication (*delete as appropriate):

Name of child:	
Date of Birth:	Class:
Address:	Daytime contact numbers:
Name of Medicine:	
Special instructions (eg take after eating):	
Are there any side effects the school should be aware of?	
Storage Instructions (eg keep refrigerated):	
Time of Dose:	Dose (quantity):
Start Date:	Finish Date:

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

Name of GP/medical professional:
Contact telephone number:

I confirm that:

- ✓ It is necessary to give this medication during the school day.
- ✓ No family member is available to administer this medicine during the school day.
- ✓ I agree to collect the medication at the end of the * **day / week / half term** (*delete as appropriate).
- ✓ This medication has been given without any adverse effect in the past.
- ✓ The medication is in the original container indicating the contents, dosage, my child's full name and is within its expiry date.

Signature of parent/carers:	
Date:	

Administration Record *(to be completed by the school)*

Name of Child:	
Date of Birth:	
Name of Medication:	
Expiry Date:	

[illegible]