CUTTHORPE PRIMARY SCHOOL

PARENTAL CONSENT

ADMINISTRATION OF MEDICINES IN SCHOOL

Name of Child _____

Today's date _____

Date of Birth _____

Class/Year _____

Doctors Name/Surgery _____

Parent Tel No. _____

MEDICINE

****Note: Medicines must be in original container and be clearly marked with your child's name & if more than one medicine is to be given, please ensure you double check all information is clear and accurate and include as much detail as possible**

Name of Medicine/strength, including Brand name (as described on the container)	**Expiration date of Medicine:**	**Dosage to be given** (How much?)**:**	**Start/Stop dates to be given:**	**Time to be given** (i.e., 9am, 11am, 1.30pm):	**Any other instructions** (i.e., 1 hour before/after food, medicine to be refrigerated)**:**

IN CASE OF EMERGENCY

Emergency contact Name _____

Daytime telephone No. _____

Relationship to child _____

Address (incl. post code) _____

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DECLARATION

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff members to assist in the administration of the medicine. I will inform the school/setting staff immediately, in writing if there is any change in dosage or frequency of the medication or if the medicine is stopped.

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

I accept that this is a service that Cutthorpe Primary School is not obliged to undertake.

I understand that I must notify Cutthorpe Primary School of any changes in writing.

Parent/Carer signature _____

Printed name _____

Date _____

Head/Staff Signature _____

Printed name _____

Date _____