



MEDICATION CONSENT FORM

St Catherine's will not give your child medicine unless you complete and sign this form, and the Headteacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Name: _____

Class: _____

Condition or illness: _____

MEDICATION:

NOTE: Medication must be in its original container as prescribed by the chemist /doctor with the prescription label

Name/type of medication (as described on the container): _____

Has your child had this medication before? YES / NO (Circle)

Time last administered: _____

For how long will your child take this medication: _____

First date and time administered: _____

Storage requirement (e.g. fridge): _____

Expiry date: _____

FULL DIRECTIONS FOR USE:

Dosage and method: _____

Is the dosage fixed or flexible (eg no of inhaler puffs can vary) _____

Timing: _____

Special Precautions: _____

Possible Side Effects: _____

Dosage (pls note if this is flexible eg asthma inhaler 2-5 puffs)

PTO

CONTACT DETAILS:

Name: _____

Daytime telephone number: _____

Relationship to Pupil: _____

I confirm that the information provided above is, to the best of my knowledge, accurate at the time of writing.

- I accept that there is no legal duty requiring the school staff to administer medication therefore it should be noted that this is a service that the school is not obliged to undertake.
- I give my consent to the nominated member of St Catherine’s first aid trained staff to administer the prescribed medication in accordance with the instructions provided above.
- I understand that the medication supplied must be suitable for use and within date.
- I understand that if my child vomits or spits out the medication given, the dose will not be repeated.
- I understand that all medication must be collected at the end of the school day on the last date it is dispensed. Any uncollected medication will be safely disposed of by the school.
- I understand that it is my responsibility to inform St Catherine’s Primary School immediately in writing if there is any change in dosage or frequency of medication and/or any other changes in circumstances or any relevant information.

Signed Parent/Carer: _____ Date: _____

Print Name: _____

Relationship to pupil: _____

Is there an expected end date for administering this medication? Y/N
Or

Is this to be administered only as and when needed