



**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? Y/N

**Data Protection Act 1998**  
*The data collected on this form will only be used for the administrative purposes of St Catherine’s Catholic Primary School and will not be disclosed to any external sources without your express written consent. These records will be treated as strictly confidential and handled in compliance with the provisions of the Data Protection Act 1998.*