



### Consent for Prescribed Medication

Name of Pupil .....

My child has been prescribed the following medication by his/her registered medical practitioner.

..... (Medication Name)

..... (Medication Dose)

..... (Administration method)

Reason for medication: .....

I request that my child be given this medication at the following times during the school day and whilst under school supervision:

.....

..... (*Intervals or circumstances*)

It is necessary for the medication to be stored by the school and made available to

..... (*Child's name*) at the necessary times, listed above.

..... (*Child's name*) **is/is not** able to administer this medication independently and therefore **will/will not** require assistance from a member of staff.

I hereby give my consent for the above to take place during school hours and while my child is under school supervision. I agree to take responsibility for the delivery of the medication to the school and ensuring that all medication is within the expiry date and clearly marked with the child's details.

Signed

.....

Parent/Carer

.....

Date *A member of staff will return medicines to parents unless*

*other arrangements are agreed by parents.*



**Administration of Prescribed Medication**

**To be completed by school personnel for every administration**

Name of Pupil .....

The above child has been prescribed the following medication by his/her registered medical practitioner.

Consent to administer has been given by ..... (parent/carer).

**Prescribed Medication**

..... (Medication Name)

..... (Medication Dose)

..... (Administration method)

**Record of Administration**

Date	Medication	Time	Dose	Administered by	Witnessed by

Any further information: