

## Consent to administer medicine

The school will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

Name of school

Ashleigh Primary School and Nursery

Name of child

Date of birth

Class

Medical condition or illness

### Medicine

Name/type of medicine  
(as described on the container)

Expiry date

Dosage and method

Timing

Special precautions/other  
instructions

Are there any side effects that the  
school/setting needs to know about?

Self-administration – Y/N

Procedures to take in an emergency

**NB: Medicines must be in the original container as dispensed by the pharmacy**

### Contact Details

Name

Daytime telephone no.

Relationship to child

Address

I understand that I must deliver the  
medicine personally to

Mrs Baker, Mrs Clarke, Ms Mitchell or Mrs  
Quinlan

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

Signature(s) \_\_\_\_\_

Date \_\_\_\_\_

# Record of medicine administered to an individual child

Name of school/setting

Ashleigh Primary School and Nursery

Name of child

Date

Time given

Dose given

Name of member of staff

Parent contacted?


Date

Time given

Dose given

Name of member of staff

Parent contacted?


Date

Time given

Dose given

Name of member of staff

Parent contacted?


Date

Time given

Dose given

Name of member of staff

Parent contacted?
