St Margaret Clitherow

Parental consent to administer medication

Name of Child:

Year Group:

Date of Birth:

Date medication provided:

Length of time medication is required:

Medical condition or Illness:

Name/Type of medicine:

Quantity required:

Time/s medication required:
(Exact timings can not be guaranteed*)

Medication Expiry Date:

Self administration Y/N:

Are there any side effects that we should be made aware of?

Yes

No

If yes please give brief details.

Note: We request that all medication is in the original container along with the manufacturer's Instructions and/or patient information leaflet. The medication MUST be clearly labelled with the childs name and a spoon/dispenser provided.

Parent/Career contact details:

Name:

Daytime telephone number:

The above informaton is to the best of my knowledge. I hereby give consent to St Margaret Clitherow to administer my childs medication as indicated above. If there is any change in dosage or frequency of the medication or the medicine is stopped I will inform the school immediately

Signature : _____ **Date:** _____

*** Note:** We will do our upmost to administer medication at the given time, however, should any medication require an exact timing and you feel the need to administer yourself then please arrange to come into school and give the medication directly to your child.