

Parental Consent to Administer Prescription Medication

Warnham Primary School will not give your child medicine unless you complete and sign this form.

Medicines must be in the original container as dispensed by the pharmacy and the manufacturer's instructions and/or Patient Information Leaflet (PIL) must be included

Child's Name	
Date of Birth	
Class	
Illness/Medical Condition	
Name of Medication	
Dose to be Given	
Time of Dose Given Before School	
Time of Next Dose	
Side effects if any / Storage needs / other instructions	

Parent/Carer's Name	
Relationship to child	
Telephone Number	
Address	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Warnham Primary School staff to administer medicine in accordance with their school policy.

I confirm that this medication has been administered to my child in the past without adverse effect. I understand that it is my responsibility to inform Warnham Primary School immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) _____ Date _____

Child Name	
Medication	
Dose Required	

Date			
Time given			
Dose given			
Administered by			
Witnessed by			

Date			
Time given			
Dose given			
Administered by			
Witnessed by			

Date			
Time given			
Dose given			
Administered by			
Witnessed by			

Date			
Time given			
Dose given			
Administered by			
Witnessed by			

Date			
Time given			
Dose given			
Administered by			
Witnessed by			