

**CONSENT FORM FOR THE ADMINISTRATION OF DRUGS PRESCRIBED BY
A DOCTOR ONLY**

My child requires the following dose of medication to be administered within school.

| Times of Day to be given or circumstances (and for how many days) | Dosage | Name of Medicine/Drug | Method of Drug Administration |
|--|---------------|------------------------------|--------------------------------------|
| | | | |

I give consent for a member of staff to administer the above medicine/drug. I understand that the same member of staff may not be available at all times and a different member of staff may administer the medicine/drug.

I undertake to deliver the correct weekly medication to the classroom assistant appointed to support my child or the Head Teacher in a child proof container/bottle, which will be administered according to my instructions above. The weekly supply of medication must be kept in a locked cabinet at all times.

I acknowledge that any staff involved in the administering of medicine in school are not qualified medical practitioners nor holding themselves out to be qualified medical practitioners.

I understand that the staff in the school will take reasonable care in the administration of medicines in school and will endeavour to respond appropriately in all circumstances should emergency treatments be required.

Signed Parent/Guardian **Date:.....**

Record of administration

| Date and Time | Dose | Signature |
|----------------------|-------------|------------------|
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