**PARENTAL CONSENT FOR SCHOOL TO ADMINISTER MEDICATION**

**The school will not give your child medication unless you complete and sign this form.**

**We are happy to administer antibiotics if children have been prescribed them 4 times a day.**

**Pupil details**

|  |  |
| --- | --- |
| Surname | First name  |
| Address  | M / F |
| Date of birth  | Year / class  |

**Medical details**

|  |  |
| --- | --- |
| Condition / illness  | Name of medication and strength  |
| Date dispensed  | Date of course completion |

|  |  |
| --- | --- |
| **Directions for use:** | **Procedures/Contacts in case of emergency:** |
| Dosage (mg/ml) |  |
| Timing |
| Side Effects (if any) |

**Your contact details**

|  |  |
| --- | --- |
| Name | Relationship to child |
| Daytime contact number | Date |
| Signature  |

**Personal Data Consent**

We will use the information given on this form for the purpose of this activity and it will be will be stored by the school for 7 years after your child leaves Year 6 (or leaves the school) and will then be destroyed in line with our Retention Policy. In the event of an urgent need we may use this information to help secure the safety of your child.

**OFFICE USE ONLY**

**Staff accepting medication**

Name: Date: Signature:

Copy given to class teacher: Y / N Input on SIMs: Y/N First Aid poster required? Y/N