ST AUGUSTINE'S CATHOLIC PRIMARY SCHOOL

Consent Form to Administer Medicines

The school/early years setting staff will not give any medication unless this form is completed and signed.

Dear Head teacher/setting lead or manager

I request and authorise that my child *****be given/gives himself/herself the following medication: (*****delete as appropriate)

Name of child		**Date of Birth**	
Address **Daytime Tel no(s)**			
School/setting			
Class (where applicable)			
Name of Medicine:			
Special precautions e.g. take after eating			
Are there any side effects that the school/setting needs to know about?			
Time of Dose		**Dose**	
Start Date		**Finish Date**	

This medication has been prescribed for my child by the GP/other appropriate medical professional whom you may contact for verification.

Name of medical professional:	
Contact telephone number:	

I confirm that:

- It is necessary to give this medication during the school/setting day
- I agree to collect it at the end of the **day/week/half term** (delete as appropriate)
- This medicine has been given without adverse effect in the past.
- The medication is in the original container indicating the contents, dosage and child's full name and is within its expiry date.

Signed (parent/carer)	
Date	