APPENDIX A – MEDICINE CONSENT FORM *(for completion by parent / guardian / carer)*

To the Head of School of Ibstock Community College

From the parent / guardian of..... **DOB:** .....
(full name of child)

My child has been diagnosed as having:

.....*(name of condition)*

They have been considered fit for school but require the following prescribed medicine to be administered during school hours:

.....*(name of medication)*

The possible side effects of taking this medicine are: .....

The medication should be dispensed as follows:

Dosage: ..... Times / intervals: ..... Strength of medication: .....

With effect from (start date) ..... Until (end date) .....

The medicine should be administered by mouth / in the ear / nasally / other .....
(delete as appropriate)

- By signing this form, I confirm that my child has taken this medicine (or at least two doses of this medicine) before and has not suffered any adverse reactions.
- I consent / do not consent for my child to take the medicine by him/herself and kindly request/do not request that you arrange for the administration of the above medicine as indicated *(delete as appropriate)*
- I consent / do not consent for my child to carry the medication upon themselves and kindly request/do not request the school store it on their behalf. This medicine does/does not need to be kept in a fridge *(delete as appropriate)*
- I undertake to update the school with any changes in medication routine use or dosage.
- I undertake to maintain an in date supply of the prescribed medication.
- I understand that the school will keep a record of medicine given and will keep me informed that this has happened
- I understand that the school cannot undertake to monitor the use of self-administered medication carried by the child and that the school is not responsible for any loss of / or damage to any medication.
- I understand that staff will be acting in the best interests of my child whilst administering medicine to them

Signed: .....*(parent / guardian)* **Date:**.....

Name of parent *(with parental responsibility)*: .....*(please print)*

Contact Details:

Home: .....Work: .....Mobile: .....

Head of School of Ibstock Community College (or healthcare / social care professional):

Signed: .....**Name**: ..... **Date:**.....

Administration of Medicines *(for school staff to complete)*

Date	Time	Dose given	Signed (by member of staff)

ADDITIONAL NOTES

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