

Appendix 1

MEDICINES CONSENT FORM



To: Miss Newman, Headteacher of Barwell C of E Academy

Full Name of Child **Class**.....

DOB:

My child has been diagnosed as having/is suffering from:

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

My child is allergic to.....

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

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

I confirm that my child has previously taken this medication with no adverse reactions.

Please administer the medication above

(dosage) **at**.....**(time)** **Strength of medication:**

.....**(intervals if needed)**

With effect from.....**Until** (or advised otherwise).

The medicine should be administered by **mouth/in the ear/nasally/other**.....

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 staff will be acting in the best interests of my child whilst administering the medicines.

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

Name of parent (please print).....

Contact Details:

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