Annex B

**Form 2 - Parental Consent for Schools/Setting to Administer Medicine**

The school will not give your child medicine unless you complete and sign this form, and has a policy that staff can administer medicine, and staff volunteer to do this.

***Note: Medicines must be in the original container as dispensed by the pharmacy***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of School/Setting | | |  | | |
|  | | |  | | |
| Date | | | Day / Month / Year | | |
|  | | |  | | |
| Childs name | | |  | | |
|  | | |  | | |
| Date of birth | | | Day / Month / Year | | |
|  | | |  | | |
| Group/Class/Form | | |  | | |
|  | | |  | | |
| Medical condition or illness | | |  | | |
|  | | |  | | |
|  | | |  | | |
|  | | |  | | |
|  | | |  | | |
| **Medicine** | | |  | | |
|  | | |  | | |
| Name/type of medicine/strength | | |  | | |
| *(as described on the container)* | | |  | | |
|  | | |  | | |
| Date dispensed | | | Day / Month / Year | | |
|  | | |  | | |
| Expiry date | | | Day / Month / Year | | |
|  | | |  | | |
| Agreed review date to be initiated by | | |  | | |
| (name of member of staff) | | |  | | |
|  | | |  | | |
| Dosage and method | | |  | | |
|  | | |  | | |
| Timing – when to be given | | |  | | |
|  | | |  | | |
| Special precautions | | |  | | |
|  | | |  | | |
| Any other instructions | | |  | | |
|  | | |  | | |
| Number of tablets/quantity to be given to | | |  | | |
|  | | |
|  | | |  | | |
| Are there any side effects that the  School/Setting needs to know about? | | |  | | |
|  | | |
|  | | |  | | |
| Self administration | | | Yes / No (*delete as appropriate*) | | |
|  | | |  | | |
| Procedures to take in an emergency | |  | | |
|  | |  | | |
| **Contact Details – First Contact** | |  | | |
|  | |  | | |
| Name | |  | | |
|  | |  | | |
| Daytime telephone number | |  | | |
| Mobile telephone number | |  | | |
|  | |  | | |
| Relationship to child | |  | | |
|  | |  | | |
| Address | |  | | |
|  | |  | | |
|  | |  | | |
| I understand that I must deliver the medicine personally to (agreed member of staff) | | | | |
|  | |  | | |
|  | |  | | |
|  | |  | | |
| **Contact Details – Second Contact** | |  | | |
|  | |  | | |
| Name | |  | | |
|  | |  | | |
| Daytime telephone number | |  | | |
| Mobile telephone number | |  | | |
|  | |  | | |
| Relationship to child | |  | | |
|  | |  | | |
| Address | |  | | |
|  | |  | | |
|  | |  | | |
| I understand that I must deliver the medicine personally to (agreed member of staff) | | | | |
|  | |  | | |
|  | |  | | |
|  | |  | | |
| Name and phone number of G.P. | |  | | |
|  | |  | | |
| The above information is, to be the best of my knowledge, accurate at the time of writing and I give consent to School/Setting staff administering medicine in accordance with the School/Setting policy. I will inform the School immediately, in writing, if there is any change in dosage or frequency of the medication of if the medicine is stopped. | | | | |
|  | | | | |
| I accept that this is a service that the School is not obliged to undertake. | | | | |
| I understand that I must notify the School of any changes in writing | | | | |
|  | |  | | |
| Date |  | Signature | |  |
|  | |  | | |