Fynamore Primary School

ADMINISTRATION OF MEDICINES

FORM OF PARENTAL/GUARDIAN CONSENT (Form 1) – STRICTLY CONFIDENTIAL

Child's Name:		Year/Class:
Address:		
Date of Birth:		
Home Tel No:		Work Tel No:
GP Surgery		GP's Tel No:
Condition/Illness:		

Statement:

I hereby request that members of staff administer the following medicines as directed below.
I understand that I must deliver the medicine personally to the school in the original container as dispensed by the pharmacy and accept that this is a service which the school is not obliged to undertake. I will inform the school/setting immediately, in writing, if there is any change required to the dosage or frequency of the medication required or if the medication is to cease.

Name (print): _____ **Relationship:** _____

Signed: _____ **Date:** _____

Name of Medicine	Dose	Prescribed by Medical Practitioner (Yes or No)	Frequency &Times for Administration	Date of Completion of Course (if known)
A				
B				
C				
D				
E				
Special Instructions/Precautions/Side Effects:				
Emergency Action:				
Other prescribed medicines child takes at home:				

Fynamore Primary School

RECORD OF PRESCRIBED/ NON-PRESCRIBED MEDICINES GIVEN TO CHILD IN SCHOOL (Form 2)

Child's Name: _____ Date of Birth: __ _____

Year/Class: _____

STRICTLY CONFIDENTIAL

Date	Time	Name of Medicine Given	Dose	Any Reactions	Name and Signature	Signature of staff witnessing invasive treatment