



Medication Consent Form

Important: School staff are not required to undertake this duty

Child's Name:	Child's Class:	Today's Date:
Child's Date of Birth:		
Parent emergency contact:	Name of Doctor:	Surgery Tel:
Name of medication:		
Reason for medication:		
Medication Storage requirements:	Dosage:	Use before date:
Period of administration:	Medication is to be administered in school between: Start Date - End Date -	
Any special guidance / frequency:		
Consequences if medication or treatment missed / action required:		
<p>PARENT / GUARDIAN CONSENT. Please read and sign.</p> <p><i>This task is being undertaken voluntarily and in a spirit of general care and concern. We will make every effort to administer this medication on time and as required.</i></p> <p>Signature:</p>		
<p>STAFF MEMBER (Name):</p> <p>DO YOU UNDERSTAND EXACTLY WHAT IS REQUIRED? YES/NO</p> <p>Signature:</p>		

1. Original: Retain with medication
2. Copy: To be filed in medical file in Headteacher's Office