RINGWOOD SCHOOL - MEDICATION CONSENT FORM

In accordance with our school medical policy based on the legislation, "Supporting Pupils with Medical Conditions in School" (DoH 2014); use this form to obtain parental /carer consent for prescribed and /or over the counter medication to be given in school.

Name of Student/Tutor Group	
Date of birth	
Emergency Contact: name + tel no.	
Medical Condition (s)	
Details of Allergies or Sensitivities	

OVER THE COUNTER MEDICINES

Tick all medication you give permission for school staff to administer in school.

PARACETAMOL TABLETS OR LIQUID	
IBUPROFEN TABLETS OR LIQUID	
ANTI-HISTAMINE TABLET OR LIQUID	
TRAVEL SICKNESS TABLETS	
THROAT LOZENGES	

PRESCRIBED MEDICATION

Medication must be in the original container or box as dispensed and labelled by the Pharmacy.

Name/Type of medication	
Expiry date	
Dosage/How taken/For how long	
Possible Side Effects	
SPECIAL INSTRUCTIONS	

CONSENT FOR SCHOOL STAFF TO ADMINSTER MEDICATION

I give consent to school staff to administer medication as above, in accordance with the school medical policy. I will inform the school, in writing, if there are any changes to this consent. If my child is to self-medicate, I will discuss this with the School Nurses or First Aiders to ensure this can be implemented safely.

I understand that there are side effects associated with all medicines and will inform the School Nurses if I am concerned about these. For more information on side effects of all medicines please refer to www.nhs.uk/medicine-guides.

I accept that medicines that have expired, or are no longer required will be returned home with my child.

Signature ____ Date ___________________________

FOR MEDICAL ROOM USE ONLY

Date, name and amount of medication received____

Amount of medication returned ____

Signature of School Nurse or Staff
Member____Date_____________________________