Medicine Consent Form

St. Cuthbert's CE Primary School Medicine Consent Form	
Child's name and class	
Child's date of birth	
My child has been diagnosed as having *(condition)*	
He/she is considered fit for school but requires the following medicine to be given during school hours	
Name of medicine	
Dose required	
Time/s of dose	
With effect from [start date]	
Until [end date]	
The medicine should be taken by *(mouth, nose, in the ear, eye, other: please provide details as appropriate)*	
I consent/do not consent for my child to take the medicine by him/herself and therefore kindly request/do not request that you arrange for the administration of the above medicine as indicated. *(Please delete as appropriate)*	
I consent/do not consent for my child to carry his/her own medicine and therefore kindly request/do not request the school to store it on his/her behalf. This medicine does/does not need to be kept in a fridge. *(Please delete as appropriate)*	
By signing this form I confirm the following statements:	
• That my child has taken this medicine or at least two doses of this medicine before and has not suffered any adverse reactions.	
• That I will update the school with any change in medication routine use or dosage	
• That I undertake to maintain an in date supply of the medication	
• That I understand the school cannot undertake to monitor the use of self-administered medication carried by my child and that the school is not responsible for any loss of/or damage to any medication	
• That I understand the school will keep a record of medicine given and will keep me informed that this has happened.	
• That I understand staff will be acting in the best interests of my child whilst administering medication.	
Signed	
Name (please print)	
Contact details	
Date	
Staff member signature	
Name (please print)	

Date	