**MEDICATION CONSENT FORM**

**School: Wath Central Primary School**

Please note: this form must be completed and signed by parent/carer before any medication is administered by school staff.

If this form is being completed for **asthma** medication, school requires an Asthma Plan provided by GP or hospital.

**WE WILL ONLY ADMINISTER PARACETOMOL/ IBUPROFEN FOR A MAXIMUM OF 3 DAYS UNLESS PROVIDED WITH A DOCTOR’S NOTE.**

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| --- | --- | --- |
| **Pupil name:** | **Pupil date of birth:**  **Class:** | |
| **Name of medication:** | **Expiry date:** | |
| **Reason for medication:** | **Prescribed/Non-prescribed**  **(please circle clearly)** | |
| **Dosage to be given:**  **Time of dosage:** | **Duration of medicine:** | |
| **Method of administration:**  (e.g. spoon/syringe) | **Self-administered: YES/NO?** | |
| **Any special precautions/instructions:** | | **First date of medication:** |
| **EMERGENCY CONTACT NAME:** | | |
| **EMERGENCY CONTACT NUMBER:** | **Relationship to child:** | |
| **PARENTAL CONSENT**  \*I consent to school staff giving my child the above medication.  \*I confirm that the medication supplied is in the original container and is labelled with my child’s name.  \*I confirm that my child has already had one dose of this medication and has not suffered any unwanted reactions. | | |
| **Name of Parent/Carer:** | **Date form completed:** | |
| **Signed by Parent/Carer:** | | |

**RECORD OF ADMINISTERED MEDICATION**

**PUPIL’S NAME:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Time** | **Name of medication** | **Dose given** | **Any reactions** | **Given by**  **(initials)** |
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