**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.**

|  |  |
| --- | --- |
| **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)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |