PARENTAL CONSENT FOR ADMINISTRATION OF MEDICINES IN SCHOOL/YOUTH CLUB

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT DRUGS BE ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF OR WHERE A CHILD IS BRINGING MEDICINE INTO SCHOOL WHICH THEY WILL SELF ADMINISTER

If you need help to complete this form, please contact the School/Youth club.

Please complete in block letters

Name of child: _____ **Date of birth:** _____

Address: _____ **School/Youth club:** _____

_____

_____

Doctor's name: _____

Non-prescribed medicines

My child requires the following non-prescribed medicines:-

_____

_____

_____

Prescribed medicines

The Doctor has prescribed (as follows) for my child:

	Name of drug or medicine to be given and any special storage instructions:	When? (eg, lunchtime, after food, when wheezy, before exercise):	How much? (eg half a teaspoon, 1 tablet, 2 drops):	Route? eg by mouth or in each ear:
1				
2				
3				
4				

Child's name: _____ can administer his/her own medication*/requires supervision to administer his/her own medicine*/requires assistance in administering his/her medicine*

I request that the treatment be given in accordance with the above information by a named member of the school/youth club staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school/centre activities, as well as on the school/youth club premises.

I undertake to supply the school/youth club with the drugs and medicines in the original duplicate labelled containers, provided by the Dispensing Chemist.

I accept that whilst my child is in the care of the school/youth club, the school/youth club staff stand in the position of the parent and that the school/youth club staff may, therefore, need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

I can be contacted at the following address/telephone during school/youth club hours:

Name: _____ **Signed:** _____

Contact address: _____ **Date:** _____

_____

_____

Contact tel no: _____

* Delete that which does not apply

THIS FORM SHOULD BE DISCARDED/DESTROYED WHEN THE MEDICATION IS COMPLETED OR CHANGED.