



GLENFIELD ADMINISTRATION OF INHALERS FORM OF CONSENT AND RECORD

Child's Name		Class / Tutor Group		Date of Birth	
Address					
Parents Name		Contact Phone Number			
Family Doctor's Name		Surgery Telephone Number			

Medicine	Associated Condition i.e. what is medication for?	Time and Frequency	Dosage and Method	Date Dispensed	Expiry Date

Please add below any information regarding how your child presents or trigger for when they need their inhaler, i.e. saying their tummy hurts, persistent coughing, if they have been out in the cold.

I accept that this is a service that the school is not obliged to undertake.

I understand that a non-medical professional will administer my child's medication, as defined by the prescribing professional only.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school and other authorised staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Parent / Carer's Signature		Print Name		Date	
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