



GLENFIELD ADMINISTRATION OF MEDICINES 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	Should it be stored in the fridge? YES/NO	Associated Condition i.e. what is medication for?	Time and Frequency	Dosage and Method	Date Dispensed	Expiry Date	Last date medication should be taken

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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