**Parental Consent to Administer Medicines & Record Form**

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| **School/Setting:** |  |
| **Name of Child:** |  | **Class/group:** |  |
| **Date of Birth:** |  | **Sex:** | male □ female □ | **Pronouns:** | he □ she □ they □ |
| **Date for review to be initiated by:** |  |
| **Medical diagnosis, condition, or illness** |
|  |
| **MEDICINE(S)** |
| **Is the Medication:** | **Prescription:**   | **Non Prescription:**  **Over the Counter**  | **Controlled:**   |
| **Name/type of medicine(s)**(As described on containers) |  |
| **Expiry date(s):** |  |
| **Dosage and method of administration:** |  |
| **Timing(s and time of previous dose:** |  |
| **Storage of medication:**  |  |
| **Special precautions or other instructions:** with food etc. |  |
| **Side effects that staff must know about or allergies:**  |  |
| **Can the child self-administer?** | YES □ NO □ | **If YES is supervision required?** | YES □ NO □ N/A □ |
| **Do any medicines need to be carried by the child on their person?** | YES □ NO □ |
| **Steps to take in an emergency:** |  |
| **PLEASE NOTE: medicines must be in the original containers as dispensed by the pharmacy.** |
| **CONTACT INFORMATION** |
| **Name:** |  |
| **Relationship to Child:** |  |
| **Address:** |  | **Work Tel. No:** |  |
| **Home Tel. No:** |  |
| **Mobile Tel. No:** |  |
| I understand medicines must be delivered and collected [describe procedure]: | YES □ NO □ N/A □ |
| I understand my child must have a working, in-date, and sufficiently full inhaler, clearly labelled with their name, which they will bring with them every day.I consent to them receiving, in an asthma emergency, salbutamol not prescribed to them. | YES □ NO □ N/A □YES □ NO □ N/A □ |
| I understand my child must have the number of working and in-date AAIs that their doctor recommends, clearly labelled with their name, which they bring with them every day.I consent to my child receiving, in an anaphylaxis emergency, adrenaline not prescribed to them. | YES □ NO □ N/A □YES □ NO □ N/A □ |
| The above information is, to the best of my knowledge, accurate at the time of writing and I consent to school/setting staff administering medicine in accordance with the Policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medicine or if the medicine is stopped. |
| **Signed:** |  | **Date:** |  |

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| **For Office Use – Receiving**  | **Date medicine received** | **Name & Quantity received** | **Expiry date** | **Prescription Label Checked and Matches** | **Blister Packs checked if appropriate** | **Time of last dose** | **Parent Sign** | **Staff Sign** |
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| **For Office Use – Returning** | **Date medicine returned** | **Quantity returned** | **Parent Sign** | **Staff Sign** |
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| **Date and Time** | **Name of Child** | **Name of Medicine** | Dose Given& How | Any Reactions | **If given - time of previous dose**This may have been administered at home and must be checked with parents.  |
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| **Signature of Staff** | **Print Name** | **Signature of Staff** | **Print Name** |
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| **Checklist for administration: Please Tick to show completed** |
| **Right Pupil**  | **Right Medicine/Check Label:**  | **Right Dose:**  | **Right Time:**  | Parental **Written** Consent Tick for Yes  |

| **Date and Time** | **Name of Child** | **Name of Medicine** | Dose Given& How | Any Reactions | **If given - time of previous dose**This may have been administered at home and must be checked with parents.  |
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| **Signature of Staff** | **Print Name** | **Signature of Staff** | **Print Name** |
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| **Signature of Staff** | **Print Name** | **Signature of Staff** | **Print Name** |
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