**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** | | | | | | | | | | | | | | | | | | | |
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| **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** |
|  | | | |  | | | |  | | |  |
| **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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| **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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| **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 | | |