**Morton Primary Academy**

Main Road, Morton, Alfreton, Derbyshire

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Headteacher: Miss L Jackson **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parental Consent for School to Administer Medicine**

The school/Setting will not give your child medicine unless you complete and sign this form, and has a policy that staff can administer medicine, and staff consent to do this.

***Note: Medicines must be in the original container as dispensed by the pharmacy***

|  |  |
| --- | --- |
| Date |  Day / Month / Year |
|  |  |
| Childs name |  |
|  |  |
| Date of birth |  Day / Month / Year |
|  |  |
| Group/Class/Form |  |
|  |  |
| Medical condition or illness |  |
|  |  |
|  |  |
|  |  |
| **Medicine** |  |
|  |  |
| Name/type of medicine/strength |  |
| *(as described on the container)* |  |
|  |  |
| Date dispensed |  Day / Month / Year |
|  |  |
| Expiry date  |  Day / Month / Year |
|  |  |
| Agreed review date to be initiated by  |  |
| (name of member of staff) |  |
|  |  |
| Dosage and method |  |
|  |  |
| Timing – when to be given |  |
|  |  |
| Special precautions |  |
|  |  |
| Any other instructions |  |
|  |  |
| Number of tablets/quantity to be given to School/Setting |  |
|  |
|  |  |
| Are there any side effects that the School/Setting needs to know about? |  |
|  |
|  |  |
| Self administration | Yes / No (*delete as appropriate*) |
|  |  |
| Procedures to take in an emergency |  |
|  |  |
| **Contact Details – First Contact** |  |
|  |  |
| Name |  |
|  |  |
| Daytime telephone number |  |
|  |  |
| Relationship to child |  |
|  |  |
| Address |  |
|  |  |
|  |  |
| I understand that I must deliver the medicine personally to (agreed member of staff) |
|  |  |
|  |  |
|  |  |
| **Contact Details – Second Contact** |  |
|  |  |
| Name |  |
|  |  |
| Daytime telephone number |  |
|  |  |
| Relationship to child |  |
|  |  |
| Address |  |
|  |  |
|  |  |
| I understand that I must deliver the medicine personally to (agreed member of staff) |
|  |  |
|  |  |
|  |  |
| Name and phone number of G.P. |  |
|  |  |
| The above information is, to be the best of my knowledge, accurate at the time of writing and I give consent to School/Setting staff administering medicine in accordance with the School/Setting policy. I will inform the School/Setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. |
|  |
| I accept that this is a service that the School/Setting is not obliged to undertake. |
| I understand that I must notify the School/Setting of any changes in writing |
|  |  |
| Date |  | Signature(s) |  |
|  |  |
| Parent’s signature |  |
|  |  |
| Print name |  |
|  |  |
| Date |  |

If more than one medicine is to be given a separate form should be completed for each one