Berkswell C of E School
Consent to Administer Medicines

The school staff will not give any medication unless this form is completed and signed.

Dear Mrs Drew,

I request and authorise that my child be given the following medication.

Name of child		Date of Birth	
Address Daytime telephone number(s)			
Year Group			
Name of medicine			
Special instructions eg take after eating			
Are there any side effects that the school needs to know about?			
Time medicine is to be given		Dosage to be given	
Start date		Finish date	

This medication has been prescribed for my child by the GP/other appropriate medical professional who you may contact for verification.

Name of medical professional	
Contact telephone number	

I confirm that:

- It is necessary to give this medication during the school day.
- I agree to collect it at the end of the day/week/half term (delete as appropriate)
- This medicine has been given without adverse effect in the past
- The medication is in the original container indicating the contents, dosage and child's full name and is within its expiry date

Signed ……parent/carer Date ……..