PUPIL ASTHMA MEDICATION CONSENT FORM

Occasional/long term prescribed medication

To be completed by the parent/carer

Name of child:	Class:	Date:
I agree to update information about my child's medical needs held by the school. I will ensure that the medicine held by the school has not exceeded its expiry date.		
❑ My child will be responsible for the self-administration of medicines as directed on this from. ❑ I agree to members of staff administrating medicines/providing treatment to my child as directed on this form.		
Name Parent/Carer:	Signature:	

Name of Medicine	Dose	Frequency/Times	Completion Date	Expiry Date

To be completed by the School Office

Date	Time Given	Medicine Given	Dose Given	Member Staff	Initials

Date	Time Given	Medicine Given	Dose Given	Member Staff	Initials
