PUPIL MEDICATION CONSENT FORM

Occasional/long term prescribed medication

To be completed by the parent/carer

Name of child:	Class:	Date:
I agree to members of staff administrating medicines/providing treatment to my child as directed on this form. I agree to update information about the child's medical needs held by the school. I will ensure that the medicine held by the school has not exceeded its expiry date. I agree to collect the medicine at the end of the day, or at the end of the course of antibiotics, and understand that if I do not, the medicine will be disposed of. **Where possible the need for medicines to be administered at school should be avoided.** **Parents are therefore requested to try to arrange the timing of doses accordingly.**		
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