Otterham C P School
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Camelford
Cornwall
PL32 9YW

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Headteacher: Mrs H Ward

MEDICATION CONSENT FORM

The school will not give your child medicine unless you complete and sign this form.

Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Date medicine provided by parent	
Expiry date	
Dosage and method	
Timing	
Time / Date Parent Last administered Dose	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	
Procedures to take in an emergency	

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

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	

The above information is, to 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.

Signature of Parent _____ Date _____

Staff Signature _____ Date _____

Date	Time Given	Dose Given	Name of Member of Staff Dispenser	Comments / Reactions