

Parental Consent Form for Administration of Medicine

This form must be completed in full and signed. The completion of this form does not act as a guarantee that the school will administer medication and the school may refuse to administer medication at any time. Any medication to be administered must have been administered previously by the parent to minimise the risk of adverse or allergic reaction to any new medication. All medication must be stored its original container and be clearly labelled with the child's name. Please refer to the Administration of Medication policy for more

miormation.	
Name of Child:	
Date of Birth:	
Form:	
Medical Condition / Illness:	
Name of Medicine:	
(as described on container):	
Is the medicine prescribed?	Yes / No
Is the medicine to be self-administered?	Yes / No
Will the student keep the medicine with them?	Yes / No
Dosage and method:	
Timing(s):	
Duration of course:	
Special Precautions:	
Are the any side effects that you know of?	
Procedures to take in an emergency:	
EMERGENCY CONTACT	
Name:	
Telephone Number:	
Relationship to Child:	
SIGNATURE:	
PRINT NAME:	
DATE:	
TOD OFFICE HOSE ONLY	

FOR OFFICE USE ONLY:

Storage location:	Medicine	Fridge	With	Student	
01603 763381	Cupboard have co	ome so they ma	y havstudent have	e it to Reception In	:10)
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Record of Administered Medication

Date	Time	Name of medicine	Dose given	Any reactions	Administered by