**THIS FORM SHOULD ONLY BE USED FOR PRESCRIBED MEDICATION**

**ADMINISTRATION OF MEDICATION - CONSENT FORM**

Daytime phone number of parent or adult contact: ………………………………………………………………….

GP name and phone number: ………………………………………………………………………………………….

Agreed review date to be initiated by: …………………………………………………… (staff member)

**The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.**

Parent’s signature ………………………………………………………. Date ……………………………..

Print name ………………………………………………………………………………………………..

IF MORE THAN ONE MEDICINE IS TO BE GIVEN, A SEPARATE FORM

SHOULD BE COMPLETED FOR EACH ONE

Name and strength of medication: ……………………………………………………………………………..

Expiry date: ……………………………………………………………………………..

How much to give (ie dose to be given): ……………………………………………………………………………..

When to be given: ……………………………………………………………………………..

Any other instructions: ……………………………………………………………………………..

………………………………………………………………………………………………………………………………

Number of tablets or other form of medication to be given to school: *………………………………………………*

………………………………………………………………………………………………………………………………

*(Note – medicines must be in the original container as dispensed by the pharmacy)*

**STUDENT’S NAME: ………………………………………….. Tutor group: ………… Date of birth: ……………**

**Home address:**