

**CONSENT FORM FOR ADMINISTRATION OF PRESCRIBED MEDICINES**

Name of child ……………………………………………………………………………….. TUTOR ………………………

Address ……………………………………………………………………………………………………………………………………..

Name of medicine ……………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………..

Reason for medicine ………………………………………………………………………………………………………………….

Dose /Frequency ……………………………………………………………………………………………………………………

Duration of medication ………………………….………………………………………………………………………………….

Expiry date of medicine …………………………………………………………………………………………………………….

Prescribed by GP YES/NO ………………………………………………………………………………………………………....

Symptoms (EPIPEN USERS ONLY) ……………………………………………………………………………………………..

Special instructions ……………………………………………………………………………………………………………………

**Paracetamol/Ibuprofen – Only one dose will be given in a school day after 11.00 a.m. Any morning dose and time given by parents to be written in planner. (If none please state none).**

**All medicines should be in their original container with their name clearly marked.**

**MY CHILD WILL BE RESPONSIBLE FOR THE SELF-ADMINSTRATION OF MEDICINES AS DIRECTED BY THIS CONSENT FORM**

PARENTS NAME: ……………………………………………………………………………………………………………

SIGNED (PARENT/CARER): ……………………………………………………………………………………………………………

EMERGENCY CONTACT NUMBER ………………………………………………………………………………………………….

DATE: ……………………………………………………………………………………………………………