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**Stoke Damerel Primary Academy**

**Consent to administer prescribed medication in school**

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| --- | --- |
| Name of child |  |
| Date of birth |  |
| Class |  |
| Medical condition or illness |  |
| Name/type of medicine*(as described on the container)* |  |
| Dosage and method |  |
| Timing |  |
| Date medicine dispensed |  |
| How long will your child need to take this medication  |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school needs to know about? |  |
| Can the medicine be self-administered by the child?  |  |
| Procedures to take in an emergency |  |
| **Medicines must be in the original container as dispensed by the pharmacy and must include your child’s name** |
| **Contact Details** |
| Name |  |
| Daytime telephone no. |  |
| Relationship to child |  |
| Address |  |
| **Prescribed medicines must be handed into the main office by an adult.** |
| Date for review (expiry date) if required |  |

In line with the procedure on the administration of medicines in school, the school will not give your child medicine unless you complete and sign this form.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school procedure. 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.

Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- |
| Date | Time | Dosage | Administered by | Signature | Witnessed by |  |
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**Administration Record**