

St Raphael's RC Primary School

Consent Form for the Administration of Medicine

DATE: _____

My child _____ in Year _____ requires the following medication to be administered in school;

Date	Name of Medicine	Method of Administration	Dosage	Time of day to be given	Medication Administered (school use only)			
					Date	Time	Signed	Witness

- I give consent for a qualified first aider to administer the above prescribed medication to the named child.
- I undertake to deliver the prescribed medication to the school office/EYFS Staff in the original child proof labelled container, which will be administered in accordance with the above instructions.
- The medication will be stored as specified on the original container.
- I understand that medicine consent forms are valid for 5 days from the date stated above, and any remaining medication will be returned.
- I acknowledge that any staff involved in the administration of medicine in school are not qualified medical practitioners nor holding themselves out to be qualified medical practitioners.
- I understand that the qualified first aiders in the school will take care in the administration of medicines in school and endeavour to respond appropriately in all circumstances should emergency treatment be required.

Signed: _____ (parent / carer)

Print: _____ (parent / carer)