**Medicine Consent Form**

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| Bishop Ellis Catholic Primary School **Medicine Consent Form** | | |
| Child’s name and class | |  |
| Child’s date of birth | |  |
| My child has been diagnosed as having *(condition)* | |  |
| He/she is considered fit for school but requires the following medicine to be given during school hours | | |
| Name of medicine | |  |
| Dose required | |  |
| Time/s of dose | |  |
| With effect from [start date] | |  |
| Until [end date] | |  |
| I consent/do not consent for my child to take the medicine by him/herself and therefore kindly request/do not request that you arrange for the administration of the above medicine as indicated. *(Please delete as appropriate)* | | |
| I consent/do not consent for my child to carry his/her own medicine and therefore kindly request/do not request the school to store it on his/her behalf. This medicine does/does not need to be kept in a fridge. *(Please delete as appropriate)* | | |
| **By signing this form I confirm the following statements:** | | |
| **My child has been seen by a GP and,**  **Has prescribed medication that needs administering during school hrs. Yes / No**  **Has been advised to continue with pain relief / Calpol Yes / No** | | |
| * That my child has taken this medicine or at least two doses of this medicine before and has not suffered any adverse reactions. | | |
| * That I will update the school with any change in medication routine use or dosage | | |
| * That I undertake to maintain an in-date supply of the medication | | |
| * That I understand the school cannot undertake to monitor the use of self-administered medication carried by my child and that the school is not responsible for any loss of/or damage to any medication | | |
| * That I understand the school will keep a record of medicine given and will keep me informed that this has happened. | | |
| * That I understand staff will be acting in the best interests of my child whilst administering medication. | | |
| Signed |  | |
| Name (please print) |  | |
| Contact details |  | |
| Date |  | |
| Staff member signature |  | |
| Name (please print) |  | |
| Date |  | |