THE DEAN ACADEMY

Parental consent for administration of medication.

The school will not give your child medicine unless you complete and sign this form.

Name of child: _____

Date of birth: _____

Tutor group: _____

Medical condition or illness: _____

Medication (as described on the container):

Name of medication: _____

Expiry date: _____

Dosage and method (i.e. oral):_____

Timing of dosage: _____

Special precautions/other instructions: _____

Are there any side effects that the school needs to know about? Yes / No

If Yes, give details: _____

Self-administration: Yes / No

Medication to be collected at the end of the day: Yes / No

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details in case of emergency:

Name: _____

Contact Number(s): _____

Relationship to child: _____

The above information is, to the best of my knowledge, accurate at the time of writing and I consent to 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.

Signature(s): _____ Date: _____