**PARENTAL CONSENT FORM FOR THE ADMINISTRATION OF MEDICINES**

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| Pupil Name |  | | |
| Form |  | | |
| Date of Request |  | | |
| Parent Name |  | | |
| Parent Contact Number |  | | |
| **Name of Medication** |  | | |
| Is this medicine | Prescribed | | Non-Prescribed |
| Condition |  | | |
| Date Prescribed |  | | |
| Details of dosage |  | | |
| Time / Frequency of dosage |  | | |
| Date course finishes |  | | |
| **Declaration by the parent / legal guardian** | | | | |
| I consent to my child being administered the prescribed / non prescribed medicine in accordance with the information above*. I understand that It is the College Policy not to force children to take their medicine if they refuse to do so. In the event of this occurring, the nominated contact will be notified.*  I understand that the Governing Body of the College and the staff cannot accept responsibility for any adverse reaction my child may suffer as a consequence of being administered the prescribed medication at my request.  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: .  Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Approval for Request** | | | | |
| **YES** | | **NO** | | |
| **Name -** | | **Signature -** | | |

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