ADMINISTRATION OF MEDICATION PARENT CONSENT FORM

Form to be completed by parents if they wish the school to administer medication, for students to self administer medication held by the visit first aider or for students to carry his/her medication whilst on a residential visit

ALL medication including non prescription medication (eg travel sickness pills, paracetemol, hayfever tablets etc.) to be taken on any residential visit must be stated in this form.

DETAILS OF VISIT:

DETAILS OF PUPIL:

Surname:		Forename:		Date of Birth:	
Tutor Group:		Male/ Female:			

MEDICATION (Please ensure medication is clearly labelled with students name, DOB, tutor group and dosage)

Condition of illness (or requirement for medication)	**Medication 1**	**Medication 2**	**Medication 3**
Name/type of medication (as described on the container/box):			
For how long will your child take this medication:			
Date dispensed:			
Dosage:			
Method of administration (eg. By mouth, injection):			
Times to be given:			
Special precautions:			
Side effects:			
Is the medication to be self administered *: YES/NO			
* NB Students using inhalers should carry and self administer the relief medication			
Procedures to take in an emergency			

Please note this is page 1 of 2 pages.

- I accept that there is no legal duty requiring school staff to administer medication therefore it should be noted that this is a service that the school is not obliged to undertake.
- I understand that I must complete this form and return it to Student Services as soon as possible.
- I understand that the named student is responsible for carrying all medication recorded on this form, clearly labelled with their name, date of birth, tutor group and dosage and it will be collected and held by Backwell School staff on reaching the destination.
- I give my consent for the nominated member of Backwell School staff to administer the above medication to the above named student.
- I understand that medication supplied must be suitable for use and within date.
- I understand that if my child vomits or spits out the medication given, the dose will not be repeated.
- I confirm that I will notify Backwell School of all changes in circumstances and/or any relevant information.

Signature(s):……………………………………………………………Date:…………………………………………………………

Please print name: ……

Relationship to pupil: ……

TO BE COMPLETED WHEN STUDENTS ARE TO PERMANENTLY CARRY THEIR MEDICATION
(Only applicable to Asthma relief medication (Inhalers)

I would like my son/daughter to keep his/her medication on him/her for use as necessary.

Signed: ………………………………………………………………………. Date: …………………………………………

Relationship to child: ………………………………………………………………………………