PARENTAL CONSENT **DATE: …….**

ADMINISTRATION OF MEDICINES IN MARLPOOL INFANT SCHOOL

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING DRUGS BE ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF OR WHERE THE CHILD IS BRINGING MEDICINE INTO SCHOOL WHICH THEY WILL SELF ADMINISTER.

If you need help to complete this form, please contact the school.

Please complete in block letters.

Name of Child: _____

Date of Birth: _____

Address: _____

Doctors Name: _____

PRESCRIBED MEDICINES

The doctor has prescribed (as follows) for my child:

Name of Drug or Medicine to be given and any special storage instructions	When? (e.g. lunchtime, after food, when wheezy, before exercise?)	How much? (e.g. half a teaspoon 1 tablet, 2 drops?)	Route, e.g. by mouth or in each ear?
1.			
2.			
3.			
4.			

Signed: …… Parent/Guardian