Appendix A: Medicine Consent Form

Ridgeway Primary 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]	
The medicine should be taken by *(mouth, nose, in the ear, other: please provide details as appropriate)*	
By signing this form I confirm the following statements:	
• 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	

Child's name -

Print name												
Signature												
Any reactions												
Dose given												
Name of medicine												
Time												
Date												