Easington C of E Primary School

Administering medication parental consent form	
PUPIL DETAILS	
Name:	
Year group:	
Date of birth:	
MEDICINE	
Medical condition or illness	
Prescribed medication	
Name and/or type of medication as described on the container	
Date dispensed	
Expiry date	
Agreed review date	
Review to be initiated by	
Dosage, timing, and method of administration	
Special precautions	
Likely side effects	
Self-administration Y/N	

PTO for signature

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy.

Signed _____ Date _____

Parent's name in BLOCK capitals:

_____

Address: _____

_____

_____

Telephone number: _____

Please give an alternative contact name and telephone number in case we cannot reach you in an emergency:

Emergency contact one

Name: _____

Telephone number: _____

Relationship to pupil: _____

Emergency contact two

Name: _____

Telephone number: _____

Relationship to pupil: _____