MEDICATION CONSENT FORM

(to be filed in Medication Administration Record File)

The Duston School will not give your child any medication unless you complete and sign this form and the Principal has confirmed that school staff have agreed to administer the medication.

DETAILS OF PUPIL

Surname: ____

Forename (s): ____

Address: ____________________________ M/F: ____________

____________________________________ DOB: ____________

____________________________________ Tutor Group: __________

Reason for medication (optional):

____

CONTACT DETAILS:

Name: ____

Daytime Contact Telephone No: __________________________

Relationship to Student: ________________________________

Address: ____

____

I understand that the medication must be delivered by a responsible adult to an authorised/appointed person in school and accept that this is a service which the school is not obliged to undertake.

Date:_____________________________ Signature (s): ____________________

MEDICATION 1.

Name/Type of Medication (as per instructions on the container):

___

For how long will your child take this medication:

___

Date Dispensed:

___

FULL DIRECTIONS FOR USE:

Dosage and amount (as per instructions on container):

___

Method:

___

Timing:

___

Special Precautions:

___

Self-Administration:

___

I would like/would not like (please delete accordingly) my son/daughter to keep his/her asthma inhaler with him/her to use as necessary.

I would like/would not like (please delete accordingly) my son/daughter to keep his/her medication on him/her for use as necessary.

(Please note that this option excludes Methylphenidate (e.g. Ritalin, Equasym) and applies only to students of secondary age)

MEDICATION 2.

Name/Type of Medication (as per instructions on the container):

For how long will your child take this medication:

Date Dispensed:

FULL DIRECTIONS FOR USE:

Dosage and amount (as per instructions on container):

Method:

Timing:

Special Precautions:

Self-Administration:

I would like/would not like (please delete accordingly) my son/daughter to keep his/her asthma inhaler with him/her to use as necessary.

I would like/would not like (please delete accordingly) my son/daughter to keep his/her medication on him/her for use as necessary.

(Please note that this option excludes Methylphenidate (e.g. Ritalin, Equasym) and applies only to students of secondary age)

MEDICATION 3.

Name/Type of Medication (as per instructions on the container):

For how long will your child take this medication:

Date Dispensed:

FULL DIRECTIONS FOR USE:

Dosage and amount (as per instructions on container):

Method:

Timing:

Special Precautions:

Self-Administration:

I would like/would not like (please delete accordingly) my son/daughter to keep his/her asthma inhaler with him/her to use as necessary.

I would like/would not like (please delete accordingly) my son/daughter to keep his/her medication on him/her for use as necessary.

(Please note that this option excludes Methylphenidate (e.g. Ritalin, Equasym) and applies only to students of secondary age)