**Parental/Guardian Medicine Consent Form .**

The school/setting will not give your child medicine unless you complete and sign this form.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of school/setting | **Up Holland High School** | | | |
| Name of child |  | | | |
| Date of birth |  |  |  |  |
| Group/class/form |  | | | |
| Medical condition or illness |  | | | |
| **Medicine** |  | | | |
| Name/type of medicine  *(as described on the container)* |  | | | |
| Expiry date |  |  |  |  |
| Dosage and method |  | | | |
| Timing |  | | | |
| Special precautions/other instructions |  | | | |
| Are there any side effects that the school/setting needs to know about? |  | | | |
| Self-administration Y/N |  | | | |
| Procedures to take in an emergency |  | | | |
| **NB: Medicines must be in the original container as dispensed by the pharmacy**  **Contact Details** | | | | |
| Name |  | | | |
| Daytime telephone no. |  | | | |
| Relationship to child |  | | | |
| Address |  | | | |
| I understand that I must deliver the medicine personally to | **Reception/Admin. Staff** | | | |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff supervising my child with medication in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) Date