Bentley Heath
Church of England Primary School

Consent to Administer Prescription Medicines within School Hours

Dear Headteacher

I request and authorise that my child be given/gives themselves* the following medication: (*delete as appropriate)

Name of child		**Date of Birth**	
Address **Daytime Tel no(s)**			
Class			
Name of Medicine:			
Special precautions e.g. take after eating			
Are there any side effects that the school/setting needs to know about?			
Time of Dose		**Dose**	
Start Date		**Finish Date**	

This medication has been prescribed for my child by the GP/other appropriate medical professional whom you may contact for verification.

Name of medical professional:	
Contact telephone number:	

I confirm that:

- It is necessary to give this medication during the school/setting day
- I agree to collect it at the end of the **day/week/half term** (delete as appropriate)
- This medicine has been given without adverse effect in the past.
- The medication is in the original container indicating the contents, dosage and child's full name and is within its expiry date.
- If this medication is an emergency auto-injector or inhaler I give consent for the school emergency medication to be used in the event my child's medication is not available.

Signed (parent/carer)	
Date	

School will not be able to support the administration of any medication unless this form is completed and signed