AM 1

PARENTAL CONSENT FORM FOR THE ADMINISTRATION OF MEDICINES

SECTION 1 PUPIL NAME	
CLASS No/ TEACHER	
DATE OF REQUEST	

SECTION 2 PARENT CONTACT NUMBER	
DAY TIME EMERGENCY CONTACT NUMBER	
PARENT(S) OR CARER(S) NAME	

SECTION 3 NAME OF MEDICATION				
IS THIS MEDICINE:	PRESCRIBED		Bottle No.	
CONDITION OR ILLNESS EG EAR INFECTION				
DATE PRESCRIBED				
DETAILS OF DOSAGE				
TIME/FREQUENCY OF DOSAGE				
DATE COURSE OF MEDICATION FINISHES				
If the medication is prescribed for 8 days or more, an individual health care plan should be completed.				

SECTION 4

DECLARATION BY THE PARENT/LEGAL GUARDIAN

I consent to my child being administered the prescribed medicine in accordance with the information above*. I understand that It is the School Policy not to force children to take their medicine if they refuse to do so. In the event of this occurring, the nominated contact will be notified.*

I understand that the LEA, Governing Body of the school and the staff cannot accept responsibility for any adverse reaction my child may suffer as a consequence of being administered the prescribed medication at my request.

Signed: _____ Date: _____.

Relationship to child: _____

AM1 (CONTINUED)

SECTION 5

APPROVAL FOR REQUEST YES / NO

HEADTEACHER____________________________ DATE____________________________

RECORD OF PRESCRIBED AND NON PRESCRIBED MEDICINES ADMINISTERED TO CHILDREN OR SELF ADMINISTERED AS PER PAGE 1

DATE	TIME	MEDICINE & DOSAGE	ADMINISTERED BY	WITNESSED BY