GLENFIELD INFANT SCHOOL: FORM OF CONSENT FOR MEDICAL TRACKER ENTRY

Administration of Medicines /Treatment

Child's Name: ____________________________ **Class:** ______________ **Date of Birth:** _________

Parent's Name: ____________________________________ **Contact Telephone Number:** _______________________

Name of Doctor's Surgery: _____________________________ **Surgery Telephone Number:** _______________________

Name of Medicine				
Should it be stored in the fridge?	Yes/No			
Associated Condition				
Dosage & Method				
Dosage Time				
Date Dispensed/Date medicine started				
Last day medicine should be taken (if short term)				
Expiry Date (if long term)				

I accept that this is a service that the school is not obliged to undertake.

I understand that a non-medical professional will administer my child's medication, as defined by the prescribing professional only.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school and other authorised staff administering medicine 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 medication is stopped.

Parent / Carer's Signature: ____________________ Print Name: ________________________ Date: _________