GLENFIELD INFANT SCHOOL: FORM OF CONSENT FOR INHALERS

Administration of Medicines / Treatment

Child's Name: _____ **Class/Tutor Group:** _____ **Date of Birth:** _____

Address: _____ **Post code:** _____

Parent's Name: _____ **Contact Telephone Number:** _____

Name of Medicine	
Associated Condition	
Dosage & Method	
Dosage Time	
Date Dispensed	
Expiry Date	

Please put any information regarding how your child presents or trigger for when they need their inhaler, i.e. saying my tummy hurts, persistent coughing, if they have been out in the cold.

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 _____