UPPER SHIRLEY HIGH: FORM OF CONSENT

To complete this online please go to: Online form: <https://forms.gle/Q9cyya4QiGig8Bzd7>

Administration of Medicines / Treatment

**We can only accept medicines if these are in-date, labelled, provided in the original container as dispensed by a pharmacist and include instructions for administration, dosage and storage.**

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

**Address:**

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| --- | --- | --- | --- | --- | --- |
| Medicine | Associated Condition | Time & Frequency | Dosage & Method | Date Dispensed | Expiry Date |
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**Parent’s Name:**  **Contact Telephone Number:**

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:

Child’s Name: Class: Date of Birth:

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| Date | Dose | Time | Signed | Witnessed |  | Date | Dose | Time | Signed | Witnessed |
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