

## Appendix 3 – Consent for medication administration form

The academy will not give your child medicine unless you complete and sign this form.

Date for review to be initiated by

Name of academy

Name of child

Date of birth

Group/class/form

Medical condition or illness


### Medicine

Name/type of medicine  
*(as described on the container)*

Expiry date

Dosage and method

Timing

Special precautions/other instructions

Are there any side effects that the academy/setting needs to know about?

Self-administration – y/n

Procedures to take in an emergency


**NB: Medicines must be in the original container as dispensed by the pharmacy**

### Contact Details

Name

Daytime telephone no.

Relationship to child

Address

I understand that I must deliver the medicine personally to

[agreed member of staff]

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to academy staff administering medicine in accordance with the Medical Conditions Policy. I will inform the academy immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) \_\_\_\_\_

Date \_\_\_\_\_