Bridstow Primary School Parental Consent for Administration of Medicines

Name of my child: **My child's teacher:** **Class:**

Name of my GP:

Name of Medicine to be given and any special storage instructions:	**When?** (eg, lunchtime, after food, when wheezy, before exercise):	**How much?** (eg half a teaspoon, 1 tablet, 2 drops):	**Route?** (eg by mouth or in each ear):	What is the **last date and time** this medicine will need to be given?
Was this medicine prescribed by the GP? Yes/No Brief description of illness: (eg ear-ache)				

Please tick ONE of the following:

- ☐ my child can **administer his/her own** medicine **OR**
- ☐ my child requires **supervision** to administer his/her medicine **OR**
- ☐ my child requires **assistance** in administering his/her medicine

I request that the treatment be given in accordance with the above information by a member of staff. I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.
I undertake to supply the school with the drugs and medicines in the original labelled containers, provided by the Dispensing Chemist.
I accept that whilst my child is in the care of the school, staff are in the position of the parent and may need to arrange any medical aid considered necessary in an emergency. If this happens, I will be told of any such action as soon as possible. I can be contacted via the following during school hours:

Your Name (Please print):

Contact telephone number (you must guarantee we can contact you immediately during the days we are administering medicine, in case of any problems):

Signed: **Date:**