PHOENIX ACADEMY

ADMINISTRATION OF MEDICATION

PARENTAL CONSENT FORM

**The school will not give your child medicine unless you complete and sign this form, and the Head Teacher has agreed that school staff can administer the medication.**

**PUPIL DETAILS**

Surname: Forename(s):

Male / Female

Date of Birth:

Condition or illness:

**PRESCRIBED MEDICATION**

Name (Type) of Medication:

For how long will your child take this medication?

Date Dispensed:

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ADMINISTRATION OF MEDICATION

PARENTAL CONSENT FORM

**FULL DIRECTIONS FOR USE:**

Dosage & Method:

Timing:

Special Precautions:

Side effects:

Procedures to take in an Emergency:

I give permission for the above medication to be administered in school

Signature: Relationship to Pupil:

Date: