Keswick School

Consent to Administer Medication in School

Please complete this form to authorise school staff to administer medication to your child during school hours.

Section 1: Pupil Information

Pupil Name: _____

Date of Birth: _____ Year Group/Form: _____

Parent/Carer Name: _____

Parent/Carer Signature: _____

Section 2: Pupil Medication

Please provide full details of medication to be administered. All medication must be provided in its original container, clearly labelled with child's name, medication name, dosage and frequency.

Name of Medication: _____

Frequency/times to be administered: _____

Dosage: _____

Route of Administered (eg oral, topical, inhaled): _____

Any specific instructions or potential side effects to be aware of: _____

_____

Reason for medication: _____

_____

Staff signature: _____ Print Name: _____

Quantity of medication returned to parent: _____ Date: _____

Staff signature: _____ Print Name: _____

Head teacher: S. Jackson, M.A. (Oxon), M.Ed., FRSA
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Section 3: Parental/Carer Consent:

I, the undersigned, give permission for school staff to administer the above-named medication to my child, [Pupil's Name], according to the instructions provided.

I understand that:

- Medication will only be administered as per the details provided on this form.
- It is my responsibility to ensure that the school has an adequate supply of the medication and that it is not expired.
- School staff are not medically trained professionals but will administer the medication in good faith and according to the instructions.
- I will inform the school immediately of any changes to my child's medication or health condition

Parental/Carer Name (please print): _____

Parent/Carer signature: _____ Print Name: _____

Date: _____

Section 4: Doctor's Authorisation (for long term medication only)

This section must be completed by a qualified medical practitioner for all long-term medications.
Long-term medication refers to any medication that needs to be administered for more than two weeks, or for ongoing conditions.

I confirm that the above-named medication is necessary for the pupil's health and well-being and should be administered during school hours as detailed above.

Doctor's Name (please print): _____

Doctor's Signature: _____ Date: _____

Contact Numbers: _____

Practice Address: _____

_____

_____