MEDICATION CONSENT FORM (Appendix 1)

Child's Name: ____

Child's Address: ____

Class: ____

Name and strength of medication: ___________________________________

Has your son had this medication before? YES / NO

Is your son capable of administering this medication himself? YES / NO

How often should dose be given: ____________________________________

Quantity to be given: ____

When to be given: ____

Why is it needed: _________________________________

Route of administration: ____

Any other instructions: ____

Any Possible Adverse Reactions:_________________________________

How to deal with any possible adverse reactions:________________________________
______

Any possible reactions to taking the medication with certain foods and drinks:_________

____

(NB: MEDICATION MUST BE IN ITS ORIGINAL CONTAINER, AS DISPENSED BY THE PHARMACY)

Name and contact telephone number of Guardians:

1.____

2.____

Name of child's GP: ____

GP's telephone number: ____

The information above is, to the best of my knowledge, accurate at the time of writing and I give my consent to staff of St. Joseph's Secondary School, administering the medication in accordance with the above instructions. 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.

Signature of parent or carer: ____

Print Name: ____

Date: ______________________________

NB: If more than one medication is to be given, a separate form should be completed for each.

RECORD OF ADMINISTRATION

Name of child: ________________________________

Date: ____

Class: ____

Name and strength of Medication ____ Expiry Date ______________

Dose and Frequency of Medication ______________________________________ Date returned: ______________

Date				
Time Given				
Dose Given				
Print Name of Staff Member Administrating Dose				
Comments				
Date & Time Parent Contacted to inform them				