**ADMINISTRATION OF MEDICATION PARENT CONSENT FORM**

Form to be completed by parents if they wish the school to administer medication, for students to self-administer medication held by a group leader or for students to carry his/her medication whilst on a residential visit. **All medication including non-prescription medication (e.g. travel sickness pills, paracetamol, hay fever tablets etc.) to be taken on any residential visit must be stated in this form.**

DETAILS OF VISIT:

DETAILS OF PUPIL: Surname: Forename: Date of Birth:

 Year Group: Male/ Female:

|  |
| --- |
| **MEDICATION** (Please ensure medication is clearly labelled with students name, DOB, year group and dosage)  |
|  | Medication 1 | Medication 2 | Medication 3 |
| Condition of illness (or requirement for medication) |  |  |  |
| Name/type of medication (as described on the container/box): |  |  |  |
| For how long will your child take this medication: |  |  |  |
| Date dispensed: |  |  |  |
| Dosage: |  |  |  |
| Method of administration (eg. By mouth, injection): |  |  |  |
| Times to be given: |  |  |  |
| Special precautions: |  |  |  |
| Side effects: |  |  |  |
| Is the medication to be self-administered \*: YES/NO |  |  |  |
| Procedures to take in an emergency |  |  |  |

 \* NB Students using inhalers should carry and self-administer the relief medication

Please be aware:

• I accept that there is no legal duty requiring school staff to administer non -prescribed medication therefore it should be noted that this is a service that the school is not obliged to undertake.

• I understand that I must complete this form and return it to the trip leader on the day of departure.

• I give my consent for a member of Wheatley Hill School staff to administer the above medication to the above named student.

• I understand that medication supplied must be suitable for use and within date.

• I understand that if my child vomits or spits out the medication given, the dose will not be repeated.

• I confirm that I will notify Wheatley Hill School of all changes in circumstances and/or any relevant information

Signature(s):……………………………………………………………Date:………………………………………………………….

Please print name: …………………………………………………………………………………………………………………….

Relationship to pupil:………………………………………………………………………………………………………………….

TO BE COMPLETED WHEN STUDENTS ARE TO PERMANENTLY CARRY THEIR MEDICATION (only applicable to Asthma relief medication (Inhalers)

I would like my son/daughter to keep his/her medication on him/her for use as necessary.

Signed: ……………………………………………………. Date: ………………………………...

Relationship to child: ………………………………………………………………………………..