PARENTAL CONSENT
TO ADMINISTER PRESCRIPTION MEDICINE

Orchard Vale Community School,
Westacott Road, Whiddon Valley,
Barnstaple, Devon EX32 8QY
T: 01271 375074
E: orchardvale@ventrus.org.uk
W: ovschool.co.uk

Notes to Parent/Guardian

1. This school will only administer your child medicine after you have completed and signed this form
2. All medicines must be in the original container as dispensed by the pharmacy, with the child's name, its contents, the dosage and prescribing doctor's name.
3. The information is requested, in confidence, to ensure that the school is fully aware of the medical needs of your child

Prescribed Medication

Date	
Child's name	
Date of birth	
Class	
Reason for medication	

Name/type of medicine (as described on the container)	
Expiry date of medication	
How much to give (i.e. dose to be given)	
Time(s) of medication to be given	
Special precautions/other instructions (e.g. to be taken with/before/after food)	
Are there any side effects that the school needs to know about?	
Procedures to take in an emergency	
I understand that I must deliver the medicine personally to the office	
Number of tablets/quantity to be given	

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Time limit – please specify how long your child needs to be taking the medication	_____day/s _____ weeks
I give permission for my child to carry their own asthma inhalers	Yes / No / Not applicable
I give permission for my child to carry their own asthma inhaler and manage its use	Yes / No / Not applicable

Details of Person Completing the Form:

Name of parent/guardian	
Relationship to child	
Daytime telephone number	
Alternative contact details in the event of an emergency	
Name and phone number of GP	

I confirm that the medicine detailed overleaf has been prescribed by a doctor, and that I give my permission for the Head Teacher (or his nominee) to administer the medicine to my child during the time he/she is at Orchard Vale Primary School.

I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine in stopped.

I understand that I am responsible for collecting and/or replacing any unused or out of date medication and that I will dispose of this medication.

The above information is, to the best of my knowledge, accurate at the time of writing.

Parent's Signature _____ Date _____
(Parent/Guardian/person with parental responsibility)