St. Augustine's Catholic Primary School

MEDICAL 'NEED TO KNOW 'AND

PARENT/GUARIDAN CONSENT FORM

Child's Name:		DOB:	Year Group:
Address:			Home Tel:
Emergency Contact's details:	Relationship to child:	Tel:	
Emergency Contact's details:	Relationship to child:	Tel:	
Name of GP:	Address:	Tel:	
Hospital:	Tel:		Consultant:
The above named child has been identified as having:			
This means that:			
The following medication is required to be taken:			
Name of Prescribed Medicine:	Expiry Date:	Dose:	Frequency/Times:
Special Instructions: Self Administer: Y/N			

Are there any side effects that the school/setting should be made aware of? Y/N
If you answered Y to the question above, please describe the side effects:
PARENT/GUARDIAN CONSENT: **I** [ ] **Parent/Guardian** agree to the school administering medicines/providing treatment to my child as directed above or in case of an emergency, as the school consider necessary in accordance with the school policy. I confirm that the above information is, to the best of my knowledge, correct at the date of writing. I will inform the school immediately, in writing, if there is any change to dosage or frequency of medication or if the medicine is stopped.

Signed:	Dated:

Note to Parents: All medicines must be prescribed by a GP/Consultant and supplied to the School Office in their original container/box as supplied by the pharmacist. Medicines must be clearly labelled with child's name, DOB, dosage and expiry date. Please ensure that you keep us informed of any change to the above medical information and that repeat medication is handed into the School Office BEFORE medicines run out/expire. Thank you.

Note to Office Staff:		
Copies of this form go to:	Class Teacher	
	Child's File	
	Medical Room	
	Medical Room Notice Board (Asthma, Nut/other allergies)	