FRIESLAND SCHOOL

MEDICAL CONSENT FORM

To be completed by the parent/guardian of any child requesting medicines be self-administered on the school premises. Staff will not prompt the student to take their medication.

Please complete in block letters

Child's Name: _____ Year/Form_____

Address: _____

_____

The Doctor has prescribed the following for my child:

Name of Drug or medication:

_____

Directions for use – Route/Amount/Frequency/Time to be taken:
(e.g. orally, one tablet, once a day at lunchtime or cream to be applied to legs at lunchtime)

Please note we will only issue medication at break or lunchtime

_____

Period medication to be taken: From (date) ____/____/____ to ____/____/____

I confirm that I wish my child _____ (name) to be issued with the above medication at the timescales detailed above. I undertake to supply the medication in the original labelled containers provided by the Dispensing Chemist. I understand that my child should only bring in enough dosage for one day (where possible). If the medication is not collected after the expiry of this consent form, then I understand that the medication will be appropriately destroyed.

Signature of parent/guardian: _____

Name: _____

Daytime Contact Number _____ Date____/_____/____