# Highcliffe St Mark Primary school

## Consent form for Administration of Medicine – Short term

| | | | |
|---|---|---|---|
| Childs Name: | | Class: | |
| Contact Tel. No. | | | |
| Reason for medication | | | |

| Name of Medication | Dose | Frequency or time(s) |
|---|---|---|
| | | |
| Expiry Date | | |

Medication should be administered
Time: Start date

Finish date of medication:

Special Instructions (if applicable

***I agree to a member of staff administering medicines or providing treatment to my child as directed above or in the case of emergency, as staff consider necessary.***

Signature:.....Parent/Carer Date: .....

Please print name

Authorised by: .....Head/Deputy/SENDCO/ Lead First Aider

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### Confirmation of Administration

**For office use only**:

| Date | Time administered | Dosage | 1st Adult Signature (Sign & print name) | 2nd Adult Signature (Sign and print name) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

To be completed by a member of school staff:
I confirm that I have checked the details of the prescribed medication against the information on the label:

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