



ELKESLEY PRIMARY & NURSERY SCHOOL

CONSENT FOR THE ADMINISTRATION OF MEDICATION

My child _____ requires the following dose of medication to be administered within school.

Time of day to be given	Dosage	Name of Medication	Method of Drug Administration

I give my consent for a member of staff to administer the above medication. I understand that the same member of staff may not be available at all times and a different member of staff may administer the medication.

I agree to deliver the correct weekly medication to the school office or classroom teacher in a childproof container/bottle, which will be administered according to my instructions above. The weekly supply of medication must be kept in a locked cabinet at all times.

I acknowledge that the staff in the school will take reasonable care in the administration of medicines in school and will endeavour to respond appropriately in all circumstances should emergency treatment be required.

Signed _____ (parent/carer) Date _____

Record of administration of medication		
Date Administered	Time Administered	Administered by (Signature)