NHS
Central and North West London
NHS Foundation Trust

CONSENT FORM TO AUTHORISE SCHOOL NURSING TEAM TO ADMINISTER MEDICINES TO AN INDIVIDUAL PUPIL Please remember to include medicines for emergency use				
Name of Pupil:				
NHS Number:			**DOB:**	
School:			**Class/Form:**	
Medical condition/illness:			**ALLERGIES:**	
Prescribed Medicine (Name and Strength)	**Form** (e.g. tablet/ Capsule/liquid)	**Dose**	**Time to be given in school**	**Special instructions**

Medicine may be given to your child by a registered nurse but they are unable to give any medicine to your child without written parental consent. Therefore, we ask you to complete & sign this form & return it to school **tomorrow** or **first day back from the School Holidays**

All medicines must be in their original containers with accurate instructions on the pharmacy label and securely packed. **It is vital that you inform school nurses immediately of any changes to your child's medication so that we can amend this form.**
This form will remain valid for 1 year unless otherwise instructed by you.

I confirm that the:	
Name of medicine on the consent form concurs with the medication supplied	**Yes/No**
Strength and the dose of medication to be administered of medication on the consent form concurs with the medication supplied	**Yes/No**
The frequency and time of administration on the consent form concurs with the medication supplied	**Yes/No**
Any special instructions e.g. PEG tube, oral, ear drops is clearly documented	**Yes/No**
I give permission for my child to self-administer their :.....medicine (specify name of medicine)	**Yes/No**

I consent for the medicines listed above to be given to the named child.	**Date**
Name of parent/carer (Please print)_____ **Signature of parent/carer**_____ **Relationship to pupil**_____ **GP name and phone number**.....	**Parent/Carer's daytime contact no**

Nurse (sign and print)	**Date**