**HCP2**

**ADMINISTRATION OF MEDICATION - PARENTAL CONSENT FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of School or Centre:** | **Dunlop Primary School & ECC** | **Class/Stage:** |  | **Name of Child’s GP:** |  |
| **Name of Child/ Young Person:** |  | **Date of Birth:** |  | **Home Address:** |  |
| **Home/Mobile Contact No.** |  | **Emergency Contact:** |  | **Emergency Contact No.** |  |

**MEDICATION**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Medication 1** | **Medication 2** | **Medication 3** |
| **Condition of illness** **(requirement for medication/treatment)** |  |  |  |
| **Name/Type of medication/ treatment as described on original container:** |  |  |  |
| **Medication / treatment prescribed by:** |  |  |  |
| **For how long will your child take this medication:** |  |  |  |
| **Date Dispensed:** |  |  |  |
| **Dosage:** |  |  |  |
| **Strength:** |  |  |  |
| **Method of administration** **(i.e. by mouth, injection)** |  |  |  |
| **Times to be given/taken:** |  |  |  |
| **Special precautions:** |  |  |  |
| **Side effects:** |  |  |  |
| **Self-administered: YES or NO** |  |  |  |

**PARENTAL STATEMENT AND CONSENT**

*These conditions are identified as appropriate within the “Supporting Children and Young People with Healthcare Needs in Education” Guidance regarding the administration of medication.*

*Delete as appropriate (i) or (ii):*

i)I confirm that my child (NAME:)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ requires the medication(s) listed and will carry the same medicine(s) at all times for taking as required and specified above.

 Or,

ii) I confirm that my child (NAME:)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ requires the medication(s) listed and that I/we will provide a supply of same medicine(s) along with written instructions for trained staff within the school or centre who have volunteered to assist in the administration.

iii) All medication(s) supplied by me/us shall be carefully checked prior to delivery to ensure that the expiry date has not been exceeded, the medication(s) will be replaced/replenished by me/us as required. I/We understand and agree that the school are not responsible for maintaining the medication(s).

iv) I/We shall also undertake to inform the head of school / centre of any changes in the medication(s) immediately, and shall provide an appropriately labelled supply accompanied with any changes to the instructions.

**Parent /Carer Full Name: Signature:** **Date:**

**(Please Print)**

**Certified By (Please Print): Signature: Date: (Head of School or Centre)**