

**Parent/Carer**

**Medication Consent Form**

The Beacon Folkestone will not give your child medicine unless you complete and sign this form as stated in Supporting Pupils with Medical Conditions Policy.

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| **Pupil Information** |

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| Pupil Name |  | | DOB |  |
| Can the pupil Self Administer?  (This means that staff do not have **any** input in the pupil’s medication) | | | | |
| Yes No | | | | |
| Date Completed | |  | | |

**Medication details to be written on reverse**

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| **PRN (prescribed) - Physical Indicators –** This medication is only given when required, **not** at a regular time/date/dose (PRN) particularly if the person that the medication is prescribed for is unable to verbally indicate they need it. For full administration guidance please see pupils individual Health Care Plan. |

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| **Good Practice Statement –**   * Accurate Clear Records: A signed letter from the parents/carer/doctor is required for all medication. * Where possible medication should be brought into school and passed to a member of staff by an adult, pupils who bring in their own medication must immediately hand it to a member of staff in their class. |

**Medication sent into school needs to be clearly labelled**

Name/Date/Dose/Administration guidance. It **must** arrive in its original packaging.

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| **Consent signage** | | | |
| The information supplied is, to the best of my knowledge, accurate at the time of writing and I give consent to trained staff at The Beacon Folkestone to administer medicine in accordance with their policy.  **I will inform trained staff in my child’s class *immediately* in writing, if there is any change in dosage or frequency of the medication or if the medicine has stopped.**  I understand that not sending in my child’s prescribed medication and or not keeping the appropriate paperwork/appointments up to date, may necessitate my child being sent home. | | | |
| **Name** |  | **Contact phone number** |  |
| **Relationship to Pupil** |  | **Signed** |  |

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| **Medication will be signed in by an Administration of Medication Trained Staff member** | | | |
| *Please do not accept this medication unless it follows The Beacon Folkestone Policy* | | | |
| Staff member name |  | Sign |  |
| Date medication received into school | |  | |

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| **1**  **Medication Details** | **Name of Medication** | | **Dosage** | **Time/s to be administered** | | | | |
|  | | |  |  |  |  |  |  |
| How is the medication administered | | | | Side effects (if known) | | | | |
|  | | | |  | | | | |
| Reason for Medication | |  | | | | | | |

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| **2** | **Name of Medication** | | **Dosage** | **Time/s to be administered** | | | | |
|  | | |  |  |  |  |  |  |
| How is the medication administered | | | | Side effects (if known) | | | | |
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| Reason for Medication | |  | | | | | | |

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| **3** | **Name of Medication** | | **Dosage** | **Time/s to be administered** | | | | |
|  | | |  |  |  |  |  |  |
| How is the medication administered | | | | Side effects (if known) | | | | |
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| Reason for Medication | |  | | | | | | |

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| **4** | **Name of Medication** | | **Dosage** | **Time/s to be administered** | | | | |
|  | | |  |  |  |  |  |  |
| How is the medication administered | | | | Side effects (if known) | | | | |
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| Reason for Medication | |  | | | | | | |

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| **5** | **Name of Medication** | | **Dosage** | **Time/s to be administered** | | | | |
|  | | |  |  |  |  |  |  |
| How is the medication administered | | | | Side effects (if known) | | | | |
|  | | | |  | | | | |
| Reason for Medication | |  | | | | | | |

**This form is to be printed double sided**

**Additional forms can be attached**