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Homefield Preparatory School

Administration of prescribed medications

**FORM OF CONSENT**

Pupil’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to appropriate members of staff administering medication to my son as detailed below:

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & reason for medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time period for medication to be given: (please tick appropriate box)

Ongoing due to a medical condition (this form should be attached to a healthcare plan)

Or, between ………………………….. and ……………………………… 

 (Specify dates)

Time medication is to be given and any relevant instructions

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medicine that has been given to my child at home TODAY and dosage (if this form is not being completed for a long term health condition)

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Other prescribed medicine that my child takes at Homefield Preparatory School

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I request that the treatment is given in accordance with the above information by a responsible member of the school staff. I understand that it may be necessary for this medication to be given during educational visits and other out of school activities, as well as on the school premises. I will inform you immediately of any changes in the above. I understand that whilst school staff will use their best endeavours to carry out these arrangements, no legal liability can be accepted by the school staff in the event of any failure to do so, or of any adverse reaction by my child to the administration of the medication. Parents are responsible for keeping all medication in date, for notifying school of any changes and removal of any out of date medication for return to the dispensing pharmacy for disposal.