**Appendix 2a: Medication Consent Form** 

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| --- | --- | --- |
| **First Name:** | **Surname:** | **D.O.B:** |
| **Medication** | **School: Beckfoot Priestthorpe Primary School** | **Year Group:** |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*person with parental responsibility*) give permission for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*child’s name*) to receive the following medication whilst at school. |
| **Name of medicine** | **Dose to be given** | **Route to be given (e.g., orally, topically, via gastrostomy, etc.)** | **Time to be given** |
|  |  |  |  |
| **This medicine will be given as prescribed by an appropriately trained member of staff while your child is at school until you inform us that it is no longer required.****If your child’s dose changes, or if this medication is stopped, please contact the school care team as soon as possible.*****Care Team lead name and contact details:*** ***S. Sumpter / L. Potter 01274 564879*** |
| **Signed:** | **Date:** |