**Appendix 2a: Medication Consent Form** 

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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:** | | | |