**HEMLINGTON HALL**

**MEDICAL PARENTAL CONSENT FORM**

Pupil Name:…………………………………………………… Class:……..……………….….…

VALID FROM DATE:………………………… EXPIRY DATE:………………………(2 weeks from start date)

I hereby declare that my child has.....………………….……………………………………..…………...

*(Please state ‘Medical Condition’)*

My child is at present taking………………………………………………………………..…..…………..

*(Please state ‘Medication Name’)*

The medication is needed at…………………………………….………………………………………....

*(Time)*

The dosage and will be given by……………………………………….……………..…………………...

*(Member of Staff)*

* I agree to update the school on any change of medication within the 2 week period.
* I will ensure the medication is within use-by date.
* I accept full responsibility for the collection and disposal of medicines appropriately. This is not the responsibility of the school.

Parent / Carer Name:…………………………………Signed:…………………………….….(Parent/Carer)

**………………………………………………………………………………………………………………..**

**For Office Use:**

**Child’s Name:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATE MEDICATION ADMINISTERED** | **TIME** | **MEDICATION AND**  **DOSAGE GIVEN** | **BY WHOM** | **SIGNED** |
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