

St. Augustine's Catholic Primary School



MEDICAL 'NEED TO KNOW 'AND PARENT/GUARIDAN CONSENT FORM

Child's Name:		DOB:		Year Group:	
Address:				Home Tel:	
Emergency Contact's details:	Relationship to child:		Tel:		
Emergency Contact's details:	Relationship to child: Tel:		Tel:		
Name of GP:	Address: Tel:		Tel:		
Hospital:	Tel:			Consultant:	
The above named child has been i	dentified as havii	ng:			
This means that:					
The following medication is requir	red to be taken:				
Name of Prescribed Medicine:	Expiry Date:	Dose:		Frequency/Times:	
Please note: As per the 'Supporting Pupils at School with Medical Conditions and Administration of medication Policy', the school will administer emergency inhalers/spacer/Auto Immune Injector when required. This policy is accessible on the school website http://www.staugustines.dorset.sch.uk					
Special Instructions:					

Self Administer: Y/N				
Are there any side effects that the school/setting should be made aware of? Y/N				
If you answered 'Y' to the question above, please describe the side effects:				
PARENT/GUARDIAN CONSENT:				
I [] Parent/Guardian agree to the school administering medicines/providing treatment to my child as directed above or in case of an emergency, as the school consider necessary in accordance with the 'Supporting Pupils at School with Medical Conditions and Administration of medication Policy'. I confirm that the above information is, to the best of my knowledge, correct at the date of writing. I will inform the school immediately, in writing, if there is any change to dosage or frequency of medication or if the medicine is stopped.				
Signed:	Dated:			

Note to Parents: All medicines must be prescribed by a GP/Consultant and supplied to the School Office in their original container/box as supplied by the pharmacist. Medicines must be clearly labelled with your child's name, DOB, dosage and expiry date. Please ensure that you keep us informed of any change to the above medical information and that repeat medication is handed into the School Office BEFORE medicines run out/expire. Please ensure you collect all medication from the school office. Thank you.

Note to Office Staff:			
Copies of this form go to:	Class Teacher		
	Child's File		
	Medical Room		
	Medical Room Notice Board		
	(Asthma, Nut/other allergies)		