

**Parental Consent Form to Dispense Medicine**

**NB: MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS PRESCRIBED AND DISPENSED BY THE PHARMACY**

**Personal Details**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Student’s Name | Date of Birth | Form |
|  | **Medical Condition/Illness** |
|  | Please give full information: |

**Medication**

|  |  |
| --- | --- |
| Name of Medicine (as described on the container) | Expiry date |
| Confirm student can self-administer the medication. Yes | Dosage and Method | Date & Time of Last DoseDate & Time of Next Dose | Date the course of medicine startsDate the course of medicine finishes |
| Special precautions/Additional Instructions |
| Are there any side effects that the school needs to know about? |
| Procedures to take in an emergency |

**Emergency Contact Details**

|  |  |
| --- | --- |
| Name of Person filling in this form  | Relationship to the student |
| Emergency Contact 1 | Emergency Contact 2 |
| Address |
| Print Name of Parent/Carer:Signature of Parent/Carer: | Date: |



**OFFICE USE ONLY**

**Record of Date and Time Taken**

|  |  |  |
| --- | --- | --- |
| **Date** | **Time** | **Dispensing Staff Initials** |
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