

# Auchengray Primary Administration of Medicine – Consent form

Auchengray Primary School will not administer medicine/undertake medical treatments unless you complete and sign this form.

## Details of Pupil

Surname: ..... Forename(s):  
.....

Address:.....  
.....  
.....

Date of Birth: ..... M  F

Condition of illness  
.....

## Medication

Name/ type of medication (as described on the container)  
.....  
.....  
..

Training required to administer medication  
.....

For how long will the pupil take this medication  
.....

Date dispensed: ..... Expiry date: .....

\*In date and properly labelled medication must be supplied:

Full directions for use  
.....  
.....  
..

Dosage and method  
.....  
.....

Timing  
.....

Special precautions  
.....  
.....

Side effects  
.....  
.....  
..

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Self-administration

.....  
.....

## Procedures to take in emergency/ refusal to take medication

.....  
.....

### Emergency contact details

1<sup>st</sup> Contact

Name.....

.

Daytime telephone number.....

Relationship to pupil .....

Address.....

.....  
.....

2<sup>nd</sup> Contact

Name.....

.

Daytime telephone number.....

Relationship to pupil.....

Address.....

.....  
.....

I understand that the medical information contained in this form may be shared with individuals involved in the care of..... (pupil's name).

Signature of parent/guardian/carer.....

Date.....

Relationship to pupil .....

**\*Parents/guardian/carers should be aware it is their responsibility to replace medicines which are past their expiry date.**

The above details and in particularly expiry date, name of medicine and dosage have been checked.

Signed (member of staff).....

Date.....