PLEASE RETURN TO STUDENT SERVICES

OAKLANDS CATHOLIC SCHOOL & SIXTH FORM COLLEGE

Administration of medicines/treatment consent form

Students personal details

Surname: …… First name: …….. Male ☐ Female ☐

DOB: ……Age: …….....Tutor Group: ……...

Address: …….

……Post Code: ……

Medical Diagnosis/Condition – Reason for medicines in school. ……

……...

……...

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

……

Please note in accordance with our health and safety policy, children under 16 years old are never to be administered aspirin or medicines containing ibuprofen unless prescribed by a doctor or pharmacist. Please confirm this has been authorised by a medical practitioner ☐

Quantity given to school:……..…. Expiry Date: ……

Dose and method of administration (the amount to be given and how the medication is to be taken eg. tablets, liquids, inhaler, injection)

……....

……....

Time of day to be taken: ……...

Are there any side effects that could affect him/her at school? …….

……

Are there any reasons/signs when this medication should not be given: ……

……..

Any other information relating to his/her healthcare in school: …….

……

Parental Agreement

I confirm that I have parental responsibility for Student Name/Form: …….. and give permission for my child to take the medication listed above during school hours. If the medicine contains ibuprofen I confirm this has been prescribed by a doctor. I understand and accept that it is my responsibility to supply the medicine in its original packaging and should the medication run out or expire, it is my responsibility to replace the items. I agree I will update the school, in writing, should there be any changes to the medical information listed above.

Parental Signature: ……. Date: …….

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Staff Use Only.

Date medication received into Student Services: ……

Original container with expiry date shown Y / N If N – date returned to parent: ……

Staff signature: ……