**Parent/Carer consent to supervise medication**

(where an individual Healthcare plan or Education Healthcare plan is not required)

*The academy will not supervise medication unless you complete and sign this form*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of child:** |  | **Tutor group:** |  |
|  |
| **Date of birth:** |   | Date form submitted:  |   |
|  |
| **Name of parent:** |   | Parents signature / consent:  |   |
|  |
| **Medical condition / illness:** |
|  |
| **Medicine/s: *Please continue on another sheet if you require more space – this must be attached and signed***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name and type of medicine** | **Amount provided** | **Dosage, method and timing** | **Date dispensed** | **Expiry date** |
|  |   |   |   |   |
|  |   |   |   |   |
|  |   |   |   |   |

 |
|  |
| **Special precautions / other instructions:** |
|  |
| **Are there any side effects to the medication/s that the academy needs to know about?** |
|  |
| **Self-administration: *(delete as appropriate)* Yes  /  No )** |
|

|  |
| --- |
| ***To be completed by the academy:*** |
| *Medication start date:* |   |
| *Medication end date:* |   |
| *Review to be initiated by:* |   |
| *Agreed review date:* |   |

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