**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:* |  | | | | |