



Roselands Infant School, Woodgate  
Road, BN22 8PD  
Tel: 01323 726764; [www.roselands.e-sussex.sch.uk](http://www.roselands.e-sussex.sch.uk)  
Email: [office@roselands.e-sussex.sch.uk](mailto:office@roselands.e-sussex.sch.uk)

### Parental Consent Form

To be completed by the parent/guardian of any child to whom drugs may be administered under the supervision of school staff.

*Please complete in block letters*

Name of Child: .....

Date of Birth: .....

Address .....

.....

Medical Diagnosis/Condition/illness: .....

Date: .....

Class: .....

Doctor's Name: .....

Doctor's telephone number: .....

The Doctor has prescribed \_\_\_\_\_

(Name of Drug or Medicine) for my child. To be given (as follows):

Question	Example	Details
How often is the medicine to be given?	<i>e.g every 4 hrs or at lunchtime</i>	
How much medicine is to be given?	<i>e.g 5ml or 1 Tablet</i>	
How is this medicine to be administered?	<i>e.g. with food, with water, dissolved</i>	

Have they had the medicine before?	Yes/No (Please cross out as appropriate)
When was the last dose given?	
How much medicine was given at this time?	
Date Medicine to start	
Date Medicine to end	

**A separate form must be completed for each medicine.**



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I accept that I must deliver the medicine personally to a member of office staff. The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school/early year's setting staff administering medicine in accordance with their policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.

I undertake to supply the school with the drugs and medicines in the original boxes/bottles/packets that are supplied by the pharmacy which are labelled with the child's name, details of the medicine and the dosage requirements. I undertake to collect any medicine from the school when my child no longer requires the medication. I understand it is my responsibility to ensure that all medicine given to school is in date.

I accept that whilst my child is in the care of the School, the School staff stand in the position of the parent and that the school staff may therefore need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

NAME OF CHILD: \_\_\_\_\_

NAME OF PARENT/GUARDIAN: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_