



## Woody's Wrap Around Care Medicine Consent Form

Child's name and class	
Child's date of birth	
My child has been diagnosed as having ( <i>condition</i> )	
He/she is considered fit for school but requires the following medicine to be given during school hours	
Name of medicine	
Dose required	
Time/s of dose	
With effect from [start date]	
Until [end date]	
The medicine should be taken by ( <i>mouth, nose, in the ear, other: please provide details as appropriate</i> )	
I consent/do not consent for my child to take the medicine by him/herself and therefore kindly request/do not request that you arrange for the administration of the above medicine as indicated. ( <i>Please delete as appropriate</i> )	
I consent/do not consent for my child to carry his/her own medicine and therefore kindly request/do not request the school to store it on his/her behalf. This medicine does/does not need to be kept in a fridge. ( <i>Please delete as appropriate</i> )	
<b>By signing this form I confirm the following statements:</b>	
<ul style="list-style-type: none"> <li>• That my child has taken this medicine or at least two doses of this medicine before and has not suffered any adverse reactions.</li> </ul>	
<ul style="list-style-type: none"> <li>• That I will update the school with any change in medication routine use or dosage</li> </ul>	
<ul style="list-style-type: none"> <li>• That I undertake to maintain an in date supply of the medication</li> </ul>	
<ul style="list-style-type: none"> <li>• That I understand the school cannot undertake to monitor the use of self-administered medication carried by my child and that the school is not responsible for any loss of/or damage to any medication</li> </ul>	
<ul style="list-style-type: none"> <li>• That I understand the school will keep a record of medicine given and will keep me informed that this has happened.</li> </ul>	
<ul style="list-style-type: none"> <li>• That I understand staff will be acting in the best interests of my child whilst administering medication.</li> </ul>	
Signed	
Name (please print)	
Contact details	
Date	
Staff member signature	
Name (please print)	
Date	



## Administration of Medicines *(for club staff to complete)*

Date	Time	Dose given	Signed (by member of staff)

### ADDITIONAL NOTES

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