

*Medical condition: \_\_\_\_\_*

### Medical Information Consent Form

ORCHARD PARK PRIMARY SCHOOL

#### Pupils Details

Name

Date of Birth:

Name of Parents/Carers:

Home Telephone Number:

Work Telephone (1)

#### Medical Details

Name of GP:

Telephone Number:

Hospital Consultant:

Hospital:

Telephone Number:

I consent to my child receiving the following medication in school

Medicine:

Dose:

Frequency:

Medicine:

Dose:

Frequency:

Medicine:

Dose:

Frequency:

I undertake to ensure that the school has adequate supplies of this/these medication(s).

I undertake to ensure that this/these medication(s) supplied by me and prescribed by my child's doctor is/are correctly labelled, in date, with storage details attached and that the school will be informed of any changes.

I understand that the medication will be given by a member of staff who has received appropriate training in accordance with the Local education Authority code of practice.

Signed

Date:

(Parent/carer)