ADMINISTRATION OF MEDICATION CONSENT FORM
(Revised GDPR)

Student Name:		**Tutor Group:**		**D.O.B:**	
Medical Condition or illness:					

Medicine *(please ensure student's name and dosage are clearly displayed on the container)*			
Name/Type of medication: *(as described on the container)*			
Date dispensed:		Expiry Date:	
Dosage and method:		Timing/s:	
Special precautions:			
Side effects that school need to be aware of:			
Plan C - **Is the medicine to be self-administered?**	☐ **Yes**	☐ **No**	
Plan A - **School to administer medicine?**	☐ **Yes**	☐ **No**	
Plan B - **Does the student have complex needs?**	☐ **Yes**	☐ **No**	
If yes, please give details:			
Is a medical **Healthcare Plan** in place?	☐ **Yes**	☐ **No**	
Procedures to take in an emergency:			

Parent/Guardian Contact Details:			
Name:		Relationship to child:	
Telephone Number:		Mobile Number:	

I understand that I must deliver the medicine personally to the School and accept that this is a service that the School is not obliged to undertake.

I understand that I must make note of the expiry date of the medication and ensure that further supplies are provided prior to the expiry date.

I understand that I must notify the School of any changes, to medication or dosage, in writing.

Signed:		Date:	
Print Name:			