MEDICATIONS RECEIVED/ PARENTAL CONSENT TO ADMINISTER MEDICINES/CHILD SELF -ADMINISTER

THIS FORM IS ONLY REQUIRED WHEN MEDICATION IS BROUGHT INTO THE SCHOOL. ALL MEDICATIONS MUST BE HANDED TO RECEPTION AT THE BEGINNING OF THE SCHOOL DAY.

All medicines are required to be in the original packaging as dispensed by the pharmacy/store when brought into the school.

PLEASE PRINT

Name of Pupil	
Date of Birth	
Year/Tutor Group	
Medical Condition/Illness	

PRESCRIBED MEDICINES

Name of Medicine	
Date/Quantity sent to SGS	
Date/Quantity Received by SGS (**SCHOOL TO COMPLETE)**	
Expiry Date	
Dosage and Method	
Timing of Medication	
Special Precautions/other Instructions	
Are there any side effects that the school need to be aware of?	
Self-administration Yes/No	

PRESCRIBED MEDICINES

Name of Medicine	
Date/Quantity sent to SGS	
Date/Quantity Received by SGS (**SCHOOL TO COMPLETE)**	
Expiry Date	
Dosage and Method	
Timing of Medication	
Special Precautions/other Instructions	
Are there any side effects that the school need to be aware of?	
Self-administration Yes/No	
Procedure in case of an emergency	

NON – PRESCRIBED MEDICINES - (OVER THE COUNTER MEDICINES)

Name/ Type of medicine	
Date/Quantity sent to SGS	
Date/Quantity Received by SGS (**SCHOOL TO COMPLETE)**	
Reason for medicine	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instruction	
Are there any side effects that the school need to know about?	

NON - PRESCRIBED MEDICINES - (OVER THE COUNTER MEDICINES)

Name / type of medicine	
Date/Quantity sent to SGS	
Date/Quantity Received by SGS (**SCHOOL TO COMPLETE)**	
Reason for medicine	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instruction	
Are there any side effects that the school need to know about?	
Procedure in case of emergency	

I give consent for medications to be administered by staff members.	Please sign for **each** consent
I give consent for my child to self - administer their own medication.	
I consent to medical information held by Spalding Grammar School to be shared with emergency services if required.	
I consent to medications being returned to my child at the end of the course/year.	
EPIPEN MEDICATION ONLY: I CONSENT TO STAFF ADMINISTERING THE SCHOOL EPIPEN IF REQUIRED	
Please print name	
A VALID ALLERGY ACTION FORM FOR THE SPECIFIED ALLERGY FROM A HEALTH PROFESSIONAL MUST BE SENT/ATTACHED	

Please return this form with the medication to reception in a sealed envelope with the students name and marked FAO Ms J Thompson. If you require further sheets or if you have any queries, please contact Ms J Thompson. 01775 765800 Ext 205