

Appendix C: Parental Request and Consent for School to Administer Medication

Beverley School and Service for Children with Autism

Parental Request and Consent for School to Administer Medication

School will not give your son/daughter any medication unless you complete and sign this form.

Name of child	
Date of birth	/ /
Medical condition(s) or illness(es)	

Medication Details (please complete separate form(s) if your son/daughter needs to take more than one type of medication at school)

Name/type of medicine <i>(as described on the container)</i>	
Dosage	
Timing	
Special precautions, method of administration etc	
Are there any side effects that the school/setting needs to know about?	
Self administration i.e. should school allow him/her to take the medicine without help/direct supervision	YES/NO (if YES, please give additional info)
Procedures to take in an emergency	

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	

I accept that this is a service that the school provides on a voluntary basis, under the terms of its Medication Policy. I understand that the school will contact me if it is not possible or reasonably practical for school to administer this medication.

I agree to notify the school in writing if there are any changes to the information given above.

Signature _____ Date _____

Name _____ Relationship to Child _____