**Permission to Administer Regular Medicine Form**

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| Child’s name: | Date of birth: |
| Child’s address: |
| Parent/Carer’s contact no: |
| Doctor’s name: | Telephone no: |
| Address of surgery: |
| Reason for medicine: |
| Name of medicine/inhaler\*: | Dosage: |
| Times to be administered: |
| Storage requirements: |

\*Please note that children who have been prescribed inhalers should have a working inhaler, clearly labelled with their name, which they should bring to BHPS Xtra. In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive Salbutamol from an emergency inhaler held by the school for such emergencies.

I give permission for medicine to be given to my child in accordance with the details above.

Parent/Carer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Carer’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Staff at BHPS Xtra will only be permitted to administer medication to your child if you complete and return this form.
* Under no circumstances will members of staff administer medication against the will of a child.
* If you have any concerns/queries, please contact the manager.