Wiltshire Council
Where everybody matters

Horningsham Primary School

LONG-TERM Prescribed Medicine Consent Form

For children who require prescribed medicines during the school day

NOTE:
- This form is for use for medicines that have been prescribed for a child to use for longer than 2 weeks.
- This form should be used for asthma inhalers and epi-pens
- This form is intended for children who may have a medical condition **requiring them to have medicine at a prescribed time which falls in the school day** or **4 doses of a medicine per day**, necessitating one of those doses to be taken during the school day.

School cannot administer any non-prescribed medicines containing analgesics (including painkillers, creams and cough mixtures, e.g. Calpol or Piriton) even if a parent gives their consent.

TO BE COMPLETED BY PARENT/CARER

Name of Child: _____ **Date of Birth:** _____

Medicine Name: _____ **Dose** _____

State the condition medicine is to treat: _____
(e.g. asthma)

Expiration Date: _____ **Once Opened Use by/within** _____
(Date on packaging)

Fridge Storage: ☐ **YES** ☐ **NO**

☐ I confirm that the medicine is in its original packaging with the prescription label

Schedule:

Start Date:		**End Date:**		**OR Tick if Ongoing:**	
Time to Administer :				**Days to Administer:** Please tick	
Notes: e.g. before food				**MON** ☐	**TUE** ☐
				WED ☐	**THU** ☐
				FRI ☐	

☐ I confirm that I will come into school and administer the medicine/s myself according to the schedule above.

or

☐ I give permission to school staff to administer the medicine/s according to the schedule above.

☐ I understand: - School are not bound by law to administer the medicine but that staff endeavour to carry out the duty of administering medication with reasonable care following County guidelines
- School cannot accept full responsibility and liability if a dose is not given, as any agreements made with families are done so in good faith
- It is my duty to collect the medicine from a member of staff at the end of the day.

Signed: _____ **Date:** _____ *Cont'd .....*

For office use only

Form checked: on _____ by _____

Expiration date to be checked termly using the Asthma Register / Log Book of Children with long-term medication

Expiration date reached on _____

Date parent notified _____ by _____

Return any unused medicine to parent