Supporting Children with Medical Needs in School

Parent Consent Form

THIS FORM HAS TO BE COMPLETED FOR EVERY CHILD

PART 1 Everyone to fill in

Child's Name: ……..… **Year:** ……..

My child has ASTHMA/MEDICAL NEEDS/ALLERGIES **YES / NO**

(PLEASE CIRCLE AS REQUIRED)

If **NO** please **sign** and **return this form to school as soon as possible**.

Parent/Carer's Name: …… **Date:** ……..……

Relationship to Child: …… **Signature:** ……..……..

If **YES** to **Asthma** please complete **PART 2 below.** If **YES** to **Allergies** please complete **PART 3.**
If **YES** to **Medical Needs** please complete **PART 4.**

PART 2 ASTHMA

1. Triggers can be ……..

2. I confirm that either (please circle correct option a, b or c)

a. The asthma medication which has been prescribed by my child's doctor will be administered by me before and after the school day and the medication is not required to be given to my child during the day.

b. My child is able to take responsibility for the self-administration of his/her asthma medication.

c. My child is not able to self-administer the contents of the reliever inhaler whilst in school which has been prescribed by his/her doctor. I am writing to ask if staff of the school will assist my child when he/she requires to use the inhaler and medication. Details of the inhaler and medication are as follows:-

Name of inhaler/medication: ……

Dosage: …… **Times:** ……..

3. The medication will be delivered by me to the school and I will ensure that a spare asthma inhaler/spacer with my child's name and class is supplied to the school for use by my child. I understand that if my child does not have an inhaler in school on his/her designated swimming day that he/she will not be able to take part in the swimming lesson.

I consent to medical information concerning my child's health to be shared with other school staff and/or health professionals to the extent necessary to safeguard his/her health.

Name of Parent/Carer: ……

Signature: …… **Date:** ……..

PART 3 ALLERGIES

It is very important that school is aware of any allergies. Please list any allergies and action/treatment that your child may require. If your child requires medication in school please fill in **PART 5**

……

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PART 4 MEDICAL NEEDS (eg eczema)

Describe and give details of child's condition, symptoms, triggers, signs, treatments, equipment or devices, environmental issues etc.

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PART 5 If your child requires medication to be taken during school hours then please state:

<table>
<tr><td colspan="2">Name of medication:</td></tr>
<tr><td colspan="2">Method of administration:</td></tr>
<tr><td>Dose:</td><td rowspan="2">Time:</td></tr>
<tr><td>Side effects/contra-indications:</td></tr>
<tr><td colspan="2">Can medication be administered by self: YES / NO
(PLEASE CIRCLE AS REQUIRED)</td></tr>
<tr><td colspan="2">Action to be taken if child refuses medication:</td></tr>
<tr><td colspan="2">Procedures in an emergency:</td></tr>
<tr><td>Storage of medication:</td><td>Fridge/ locked cupboard</td></tr>
</table>

I understand that I must deliver the medication personally to the school office and I request that authorised staff administer the above medication to my child. I accept that his is a service which the school is not obliged to undertake.

I consent to medical information concerning my child's health to be shared with other school staff and/or health professionals to the extent necessary to safeguard his/her health.

I confirm the medication has been prescribed by a doctor/consultant and that this information has been provided in consultation with my child's doctor/consultant.

Each item of medication must be delivered in its original container and must be clearly labelled with the following information: pupil's name, name of medication, dosage, frequency of dosage, date of dispensing, storage requirements (if necessary) and expiry date.

Name of Parent/Carer: (in Capitals) ……

Signature: …….. **Date:** ……