Dear Parent/Carer,

All schools and academies must obtain written consent from parents/carers before medication can be administered to a student.

Students are not permitted to carry their own medication in the Academy and only medicines supplied by parents in advance will be given. All medicines are to be clearly labelled with the student’s name, the dose and frequency. If the medication is prescribed, then the label should be clearly visible with the pharmacy contact details and expiry of the drug accessible.

If your child’s medical condition is more complex than this form allows you to explain, please contact Jill Hackett via the Academy’s main phone line 01737 551161 or at

[jill.hackett@oasiscoulsdon.org](mailto:jill.hackett@oasiscoulsdon.org)

Please return this form to the Well-Being Centre.

**Student name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mentor Group:**\_\_\_\_\_\_\_\_

**Please indicate whether this medication is for short or long term daily use, or to be used only when required:**

**Short term daily use - dates to be taken** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Long term daily use**

**To be used only as and when required -** please give examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Name of Medication:** (as described on container) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dosage and Method:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/Carer)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/Carer)

Date ------/--------/20------

*I consent to my child being supervised at the Academy whilst taking the above medication and agree to deliver the medicine personally to the School Office and to inform Jill Hackett in the Well Being Centre of any changes.*