SOUTH LANARKSHIRE COUNCIL

**DEPARTMENT OF EDUCATION**

**ADMINISTRATION OF MEDICINES**

**PARENTAL CONSENT FORM**

# School: Saint John’s Primary

**Name of Pupil...……………………….………………………………………..**

**Date of Birth …..…………………….…………………………………………**

**Name of Medicine...……………………………………………………………**

**Dosage …………….……………………………………………………………**

**Timing …………….……………………………………………………………**

**Name of General Practitioner …………..……………………………………**

**Address ………………………………………..………………………………**

**………………………………………………….………………………………**

**Telephone No: …………………………………..…………………………….**

**I would confirm that my child …………………………………. requires the**

**above medicine and that it can be administered by a non-medically qualified**

**person.**

**Home Address …………………………………………………………………**

**…………………………………………………………………………………..**

**Telephone No ….………………………………………………………………**

**Signature of Parent/Guardian ………………………………………………..**

**Date ……………………………………………………………………………..**

**If no telephone, please give the telephone number of a neighbour or relative**

**Name of neighbour ……………………………………………………………..**

**Telephone No ……………………………………………………………………**