ADMINISTRATION OF MEDICINES / TREATMENT
FORM OF CONSENT (Form 1) - STRICTLY CONFIDENTIAL

Child's Name …….
Class/Tutor group…….

Date of Birth …….....
Medical Condition/Illness…….....

Name of GP and Practice……

I hereby request that members of the school staff administer the following medicines prescribed for my child by his/her GP/Specialist as directed below. I understand that I must deliver the medicine personally to the school office and accept that this is a service which the school is not obliged to undertake.

Parent/Carer Signed…….Date……
Parent/Carer Emergency Contact Number……...

Name of medicine/s…….
(as described on container)

Dose (eg 1 x 5ml spoonful) …….

MEDICINE DOSAGE

Medicine	Time/Frequency	Dose	Course end date	Stored in fridge yes/no

Special Instructions/Precautions/Side Effects:

Allergies:

Other prescribed medicines child takes at home:

PTO for record of medicines administered

St Laurence School

Westwood with Iford Primary School

Winsley Primary School

Churchfields The Village School

Fitzmaurice Primary School

Christ Church CE VC Primary School

ADMINISTRATION OF MEDICINES / TREATMENT
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Date	Time	Name of medicine	Dose	Staff Signatures	Hand over to parent signature

PTO for record of medicines administered

St Laurence School

Westwood with Iford Primary School

Winsley Primary School

Churchfields The Village School

Fitzmaurice Primary School

Christ Church CE VC Primary School