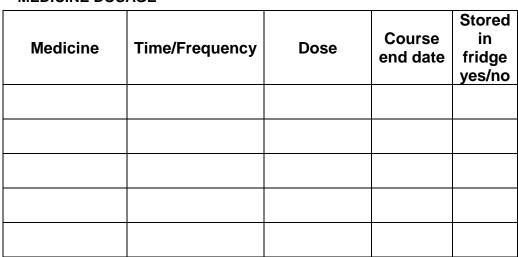
## **ADMINISTRATION OF MEDICINES / TREATMENT** FORM OF CONSENT (Form 1) - STRICTLY CONFIDENTIAL

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							
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







Winsley Primary School



Churchfields The Village School



Fitzmaurice Primary School



Christ Church CE VC Primary School

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

Date	Time	Name of medicine	Dose	Staff Signatures	Hand over to parent signature











