

ADMINISTRATION OF MEDICINES/TREATMENT

FORM OF CONSENT – STRICTLY CONFIDENTIAL

Child's Name: _____ Class _____

Address: _____

Date of Birth: _____ M/F: _____

Home Tel No: _____ Work Tel No: _____

GP's Practice: _____ GPs Tel No: _____

Condition/Illness: _____

I hereby request that members of 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 and accept that this is a service which the school is not obliged to undertake.

Signed:

Date:

Name of Medicine	Dose	Frequency/Times	Date of Completion of Course (if known)
A			
B			
C			
D			
E			
Special Instructions/Precautions/Side Effects:			
Allergies:			
Other Prescribed medicines child takes at home:			

