Consent form for administration of medicine/treatment

Child's name ____

Address ____

____

Parent/Carer name: ___________________________ Telno: ________________________

GP's name and address ____

____

GP's telephone number ______________________________

Please tick the appropriate box

☐ My child will be responsible for the self-administration of medicines as listed below

☐ I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of an emergency, as staff consider necessary

Signed ____ (Parent/Carer) Date____________

All prescribed medications must have a prescription label with name, date, dosage, expiry

Name of medicine	**Dose**	**Frequency/times**	**Completion date of course**	**Expiry date of medicine**
Special instructions				
Allergies				
Other prescribed medicines child takes at home				

OFFICE USE ONLY

Record of prescribed medicines given to children in school time

Name of child ___________________________________

	Date	Time	Medicine Given	Dose	Signature
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
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