Preston Candover Primary School

Administration of Medicines/Treatments Consent Form

Child's Full Name …….. **Class** ……

Address ……

……

Parent(s) Tel. Nos. **Home** …….. **Work** ……

Mobile ……

GP Name …….. **Tel No** ……

Please tick the appropriate box

☐ My child will be responsible for the self-administration of medicines as directed below (unless it is an oral Medicine)

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

Signed …….. **Date** ……..
(Parent/guardian)

Name of Medicine	Dosage	Frequency/ Times	Completion date of course	Expiry date of medicine
A				
B				
C				
D				
E				
Special Instructions:				
Allergies:				
Other prescribed medicines child takes at home:				

Preston Candover Primary School

Record of prescribed medicines given to child in school

Child's Full Name …….. **DOB** ……

	Date	Time	Medicine given	Dose	Signature
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					