Preston Candover CE Primary School

Administration of Medicine/Treatment Consent Form

Childs Full Name	
Year/Class	
Date of Birth	
Name of GP	
Medical condition or ilness	

Name(s) of Medicine	Dosage	Frequency/Time(s)	Completion date of course	Expiry date of medicine
1				
2				
3				
4				

Special precautions/other instructions:	
Are there any side effects the school should know about?	
Allergies:	
Other prescribed medicines child takes at home:	

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.	

Medicines must be named and in the original container as dispensed by the pharmacy

Contact Details

Emergency Contact Name	
Daytime Telephone No.	
Relationship to Child	
Address	

Declaration

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature _____ Date _____

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Record of prescribed medicines given to child in school

Childs Full Name _____ Date of Birth _____

Date	Medicine Given	Time	Dose	Signature