ADMINISTRATION OF MEDICINES/TREATMENT

FORM OF CONSENT – STRICTLY CONFIDENTIAL

Child's name: ___________________________ **Class:** ________________

Address: ____

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Date of birth: __________________________ **M/F:** __________________

Telephone no.: __________________________

GP's Practice: __________________________ **Tel:** ____________________

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)
Special instructions/precautions/side effects:			
Allergies:			
Other prescribed medicines child takes at home:			