Administration of Medicines & Treatment Consent Form

Name of School	
Name of Child	
Address of Child	

Parents' Home Telephone No.	
Parents' Mobile Telephone No.	

Name of GP	
GP's Telephone No.	

Please tick the appropriate box

My child will be responsible for the self-administration of medicines as directed below	
I recognise that school staff are not medically trained	

Signature of parent or carer	
Date of signature	

Name of Medicine	Required Dose	Frequency	Course Finish	Medicine Expiry

Special Instructions	

Allergies	

Other Prescribed Medicines	