Administration of Medicines & Treatment Consent Form

Name of School	St Matthew's CE Primary School
Name of Child	
Date of birth 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 agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of emergency, as staff may consider necessary	
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	

Record of Prescribed Medicines Given to a Child in School

No.	Date	Time	Medicine Given	Dose	Signature

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No.	Date	Time	Medicine Given	Dose	Signature