Form 1: Administration of medicines/treatment consent form

School name: ______________________

Child's name: ______________________

Child's address: ______________________

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Parents' home telephone no: ______________________

Parents' work telephone no: ______________________

Parents' mobile telephone no: ______________________

Name of GP: ______________________

GP 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 administrating medicines/providing treatment to my child as directed below or in the case of an emergency, as staff may consider necessary ☐

I recognise that school staff are not medically qualified ☐

Signed (parent/carer): ______________________

Date: ______________________

Name of medicine	Dose	Frequency	Completion date of course (if known)	Expiry date of medicine

Special instructions:

Allergies:

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Other prescribed medicines: