**ADMINISTRATION OF MEDICINES / TREATMENT**

**FORM OF CONSENT (Form 1) - STRICTLY CONFIDENTIAL**

Child's Name: _____ Class: _____

Address: _____

_____

Date of Birth: _____ M/F: _____

Home Tel No: _____ Work Tel No: _____

GP's Practice: _____ GP's Tel No: _____

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) |
|---|---|---|---|
| A | | | |
| B | | | |
| C | | | |
| D | | | |
| E | | | |
| Special Instructions/Precautions/Side Effects: | | | |
| Allergies: | | | |
| Other prescribed medicines child takes at home: | | | |

**RECORD OF INVASIVE TREATMENT GIVEN TO CHILD IN SCHOOL (Form 2)**

Child's Name: _____ Date of Birth: _____

Class: _____

**STRICTLY CONFIDENTIAL**

| Date | Time | Name of Medicine Given | Dose | Any Reactions | Signature | 2nd Signature of staff witnessing treatment – NO treatment to be given until this column signed |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |