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: _____

Medication: Prescribed by GP/Specialist Non-Prescribed Please circle

I hereby request that members of staff administer the following medicines as directed below. I understand that I must deliver the medicine personally to the school in the original container as dispensed by the pharmacy and accept that this is a service which the school is not obliged to undertake. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

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 PRESCRIBED/ NON-PRESCRIBED MEDICINES GIVEN TO CHILD IN SCHOOL (Form 2)

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Child's Name: _____ Date of Birth: _____

Class: _____

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Date	Time	Name of Medicine Given	Prescribed or Non-Prescribed	Dose	Any Reactions	Signature	Signature of staff witnessing invasive treatment

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CONFIRMATION BY MEDICAL PRACTITIONER OF PRESCRIBED MEDICATION (FORM 3)

To be completed by a Medical Practitioner i.e. Family doctor, School Medical Officer, Consultant, etc.

To: _____

School/Centre: _____

Name of Child: _____Date of Birth: _____

Address: _____

_____

I CONFIRM that I have prescribed medication which will need to be taken during school hours, for the above-named child.

Name of Medication: _____

Length of time medication is required (give dates): _____

Dosage: _____

Any special requirements (e.g. Timing, taken with meals, etc.): _____

_____

Signature: _____

Date: _____

GP/Official Stamp: _____