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 PRESCRIBED MEDICINES GIVEN TO CHILD IN SCHOOL (Form 2)

Wiltshire Council
Where everybody matters

Child's Name: _____ Date of Birth: _____

Class: _____

STRICTLY CONFIDENTIAL

Date	Time	Name of Medicine Given	Dose	Any Reactions	Signature	Signature of staff witnessing invasive treatment

STRICTLY CONFIDENTIAL

Wiltshire Council
Where everybody matters

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: _____