ADMINISTRATION OF MEDICINES / TREATMENT

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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:

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RECORD OF PRESCRIBED MEDICINES GIVEN TO CHILD IN SCHOOL (Form 2)

Child's Name: ____ Date of Birth: ________________________

Class: __________________________

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Date	Time	Name of Medicine Given	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: ____