Administration of Medicines and Treatment Consent Form

Name of Student:	
Tutor Group:	

Parents' Home Telephone No:	
Parents' Mobile Telephone No:	

- **I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of emergency, as staff may consider necessary**
- **I recognise that school staff are not medically trained**

Signature of parent or carer:	
Date of signature:	

Name of Medicine	Required Dose	Frequency	Course Start	Course Finish
Special Instructions				

Name of Medicine	Required Dose	Frequency	Course Start	Course Finish
Special Instructions				

Name of Medicine	Required Dose	Frequency	Course Start	Course Finish
Special Instructions				

Name of Medicine	Required Dose	Frequency	Course Start	Course Finish
Special Instructions				

Medicine Administered	Dose	Date	Time	Staff Signature	Staff Signature