

## Administration of Medicines & Treatment Consent Form

<b>Name of School</b>	ST. PETER'S C. OF E. (AIDED) JUNIOR SCHOOL, FARNBOROUGH
<b>Name of Child</b>	CLASS:
<b>Address of Child</b>	

<b>Parents' Home Telephone No.</b>	
<b>Parents' Mobile Telephone No.</b>	

<b>Name of GP</b>	
<b>GP's Telephone No.</b>	

Please tick the appropriate box

<b>My child will be responsible for the self-administration of medicines as directed below</b>	
<b>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</b>	
<b>I recognise that school staff are not medically trained and cannot be held responsible for the delivery of the medication, nor for any adverse reaction to it.</b>	

<b>Signature of parent or carer</b>	
<b>Date of signature</b>	

Name of Medicine	Required Dose	Frequency	Course Finish	Medicine Expiry

<b>Special Instructions</b>	
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<b>Allergies</b>	
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<b>Other Prescribed Medicines</b>	
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