Wiltshire Council
Where everybody matters

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.

Please note that the school will use all reasonable effort to ensure that parents request for the administering of medicine are complied with, but won't be held responsible for failure to do so or for any adverse reactions.

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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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: ____