Long Term Medication Consent Form

Child's Full Name	
Date of Birth	
Parent/Carers Name	
Dr's Name	
Dr's Address	
Dr's Telephone Number	

Name/Type of Medication	
Storage details	
Dosage	
Time to be given	
Start of prescription	
Parent/Carer signature	
Authorised signature	
Date signed	

PLEASE NOTE

Medication will not be administered if you do not complete and return this form. Under no circumstances will members of staff administer medication against the will of a child.

Out of date medication will be disposed of.