

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.

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:			

**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: _____