

Administration of Medicines & Treatment Consent Form

Name of school	Westfields Infant School
Name of child	
Child's date of birth	
Address of child	
Parent's name and address	
Parent's emergency contact telephone numbers	
Name of GP and telephone number	

I agree to members of staff administering medicines in accordance with the school policy and providing treatment to my child as directed below or in the case of emergency, as staff may consider necessary.	
My child will be responsible for the self-administration of medicines as directed below	
I recognise that school staff are not medically trained	

Medicines must be in the original labelled container as dispensed by the pharmacy				
Name of Medicine	Required Dose	Frequency / Time	Course Finish	Medicine Expiry

Special instructions	
Allergies	
Other prescribed medicines	

The above information is, to the best of my knowledge, accurate at the time of writing. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. All medicines are to be collected daily and at the end of the course.	
Signature of parent or carer	
Date	