Administration of Long Term Medicines/Treatment
(Form of Consent)

Childs Name:	**Class Teacher/ Class:**
Address:	

Parent's Home Tel:	**Mobile:**
Childminder Home Tel:	***Mobile***
GP Name:	**GP Tel Number:**
Child's DOB:	

If your child has been unwell and needs to take medicine prescribed by your Doctor, we can administer it. However, the medicine must be delivered in person to the office in its named/original packaging, labelled with your child's name. We are unable to administer any medicine which is not prescribed. I understand that I am responsible for providing medicine in date, clearly labelled with contents, dosage, and child's name. I accept that this is a service which the school is not obliged to undertake. I am also responsible for the disposal of any medication supplied.

Tick appropriate box ☐ ☐	**I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of emergency, as staff consider necessary. I understand that I am responsible for providing medicine in date and delivered personally to the school office and accept that this is a service which the school is not obliged to undertake.**

Signed (Parent/Guardian):	**Date:**
Signed (on behalf of parent /childminder)	***Printed:***

Name of Medication	**Dose**	**Time/s**	**Storage details**

Date Administered:	Name of Medication	Time Medication given	Dosage	Signed	Printed