ADMINISTRATION OF MEDICINES / TREATMENT

Wiltshire Council
Where everybody matters

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: _____

Medication: Prescribed by GP/Specialist Non-Prescribed Please circle

I hereby request that members of staff administer the following medicines as directed below. I understand that I must deliver the medicine personally to the school in the original container as dispensed by the pharmacy and accept that this is a service which the school is not obliged to undertake. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

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:			

RECORD OF PRESCRIBED/ NON-PRESCRIBED MEDICINES GIVEN TO CHILD IN SCHOOL (Form 2)

Wiltshire Council
Where everybody matters

Child's Name: _____ Date of Birth: _____

Registration Group: _____
STRICTLY CONFIDENTIAL

Date	Time	Name of Medicine Given	Prescribed or Non-Prescribed	Dose	Any Reactions	Signature	Signature of staff witnessing invasive treatment

Wiltshire Council

Where everybody matters