ADMINISTRATION OF PRESCRIBED MEDICINE/TREATMENT

FORM OF CONSENT

Childs Name……..

Address……..

Home Tel No……..

Work Tel No……

I hereby request that members of staff from Covingham Park Primary School to administer the following medicine prescribed for my child by the GP/Specialist as directed below, or in the case of an emergency, as staff consider necessary.

Signed……..
Date……

Name of medicine	Dose	Frequency/Time	Date of completion of course (if known)

Special Instructions

Allergies

Pupils Name……

Date	Time	Name of Medication	Dose given	Any Reactions	Signature of Staff	Print Name