

# 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

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Allergies

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Pupils Name.....

[illegible]

