LYTCHETT MATRAVERS PRIMARY SCHOOL: FORM OF CONSENT

Administration of Medicines / Treatment

Child's Name: _____ **Class/Tutor Group:** _____ **Date of Birth:** _____

Address: _____

Parent's Name: _____ **Contact Telephone Number:** _____

Family Doctor's Name: _____ **Surgery Telephone Number:** _____

Medicine	Associated Condition	Time & Frequency	Dosage & Method	Date Dispensed	Expiry Date

I accept that this is a service that the school is not obliged to undertake.

I understand that a non-medical professional will administer my child's medication, as defined by the prescribing professional only.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school and other authorised staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Parent / Carer's Signature: _____ Print Name: _____ Date: _____

Date	Dose	Time	Signed	Witnessed		Date	Dose	Time	Signed	Witnessed

Date	Dose	Time	Signed	Witnessed		Date	Dose	Time	Signed	Witnessed

Child's Name: _____ Class: _____ Date of Birth: _____