FYNAMORE COMMUNITY PRIMARY SCHOOL

CONSENT FOR THE SCHOOL TO ADMINISTER MEDICATION OR TREATMENT

STRICTLY CONFIDENTIAL

Name of child: …… Class Teacher: ……..…..……

I give consent for a member of staff to administer to my child the medication/treatment detailed below. It is clearly labelled indicating content, dosage and child's full name.

I understand that the medication must be delivered and collected from the school office by an adult. I authorise a member of staff to administer the medication or treatment detailed below. I accept that this is a service which the school is not obliged to undertake.

Name of Medication/Treatment	Dose	Time	Date of completion (*if known*)
1.			
2.			
3.			

Signed: _____ Date: _____
Parent/Guardian

Please note*:*

The school will not accept medication unless this consent form is completed and signed by the parent or legal guardian of the child and the Headteacher agrees with the administration of the medicine. The Governors and Headteacher reserve the right to withdraw this service.

For office use only

Medication Given

Date							
Time							
Dosage							
Initials							

Date							
Time							
Dosage							
Initials							