

## **ADMINISTRATION OF MEDICINES**

## FORM OF PARENTAL/GUARDIAN CONSENT (Form 1) - STRICTLY CONFIDENTIAL

Child's Name:	Year/Class:	Year/Class:							
Address:									
Date of Birth:									
Home Tel No:		Work Tel No:							
GP Surgery		GP's Tel No:	GP's Tel No:						
Condition/Illness:									
Statement:									
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 required to the dosage or frequency of the medication required or if the medication is to cease.  Name (print):									
	Date:								
Signed:			Date:						
Name of Medicine	Dose	Prescribed by Medical Practitioner	Frequency &Times for Administration	Date of Completion of					
-		Prescribed by Medical	Frequency &Times	Date of					
Name of Medicine		Prescribed by Medical Practitioner	Frequency &Times	Date of Completion of					
Name of Medicine		Prescribed by Medical Practitioner	Frequency &Times	Date of Completion of					
Name of Medicine  A B		Prescribed by Medical Practitioner	Frequency &Times	Date of Completion of					
Name of Medicine  A B C		Prescribed by Medical Practitioner	Frequency &Times	Date of Completion of					
Name of Medicine  A B C	Dose	Prescribed by Medical Practitioner	Frequency &Times	Date of Completion of					
Name of Medicine  A B C D	Dose	Prescribed by Medical Practitioner	Frequency &Times	Date of Completion of					

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

Year/Class: \_\_\_\_\_

Wiltshire	<b>Council</b>
	Where everybody matters

Child's Name:	Date of Birth:

## STRICTLY CONFIDENTIAL

Date	Time	Name of Medicine Given	Dose	Any Reactions	Name and Signature	Signature of staff witnessing invasive treatment