GODOLPHIN PRIMARY SCHOOL **Administration of Medicines & Treatment Consent Form**	

Childs Name:
Class:
Parent's Name:
Parent Emergency contact details:
Name of Doctor:
Doctor's address:
Nature of Illness:
Medication prescribed:
Dosage:
Time to be given in school:
Is the medication to be self-administered? Y/N:
Any special instructions:
Any allergies known:
SCHOOL USE ONLY: Time given: **(cont. overleaf) Signed:**

I agree to my child receiving the above medication as documented on this form whilst in the care of school staff. I understand that I am responsible for ensuring the appropriate information, and medication, has been supplied. I confirm that I am the parent of the above child and as such, I am able to give authority for the above medication.

I recognise that school staff are not medically trained.

Print Name:

Signed:

Date:

SCHOOL USE ONLY:		
Date:	Time given:	Signed: