ADMINISTRATION OF MEDICINES
FORM OF CONSENT FOR SHORT TERM MEDICATION

Child's Name: _____ Class: _____

Address: _____

Home Tel No: _____

Work Tel No: _____

Mobile No: _____

GP Name and Tel No: _____

*I hereby request that a member of staff administer the following medicines prescribed for my child by his/her GP/Specialist, as directed below.
OR
*I hereby request that my child (named above) self-administers his/her medication as needed. Under these circumstances I, as a parent, am responsible for ensuring that the correct dosage is administered.

*please delete as appropriate

Name of Medicine	Dose	Frequency/Times	Date of completion of course (if known)

Signed: _____ Date: _____
(Parent/Guardian)