SOUTHSEA INFANT SCHOOL

ADMINISTRATION OF MEDICINES
FORM OF CONSENT
*

*FOR A **SINGLE** ILLNESS*

CHILD'S NAME:

CHILD'S CLASS:

PARENTS PHONE NUMBER :
Home:
Work:

I agree to members of staff administering medicines to my child as directed below or, in the case of an emergency, as staff consider necessary

SIGNED.....
DATE.....
(PARENT/CARER)

DATE	NAME OF MEDICINE	DOSE	TIME MEDICINE SHOULD BE TAKEN	TIME OF LAST DOSE (TO BE COMPLETED BY PARENT)	COMPLETION DATE OF COURSE	MEDICINE RETURNED TO PARENT

SPECIAL INSTRUCTIONS: