Jefferys education trust

HOLLYBROOK INFANT SCHOOL

HOLLYBROOK INFANT SCHOOL: FORM OF CONSENT

Administration of Medicines / Treatment

Child's Name: _____ Class/Tutor Group: _____ Date of Birth: _____

Address: _____

Parent's Name: _____ Contact Telephone Number: _____

Family Doctor's Name: _____ Surgery Telephone Number: _____

Medicine	Associated Condition	Time & Frequency	Dosage & Method	Date Dispensed	Expiry Date

I accept that this is a service that the school is not obliged to undertake.

I understand that a non-medical professional will administer my child's medication, as defined by the prescribing professional only.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school and other authorised staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Parent / Carer's Signature: _____ Print Name: _____ Date: _____

Date	Dose	Time	Signed	Witnessed	Date	Dose	Time	Signed	Witnessed

Date	Dose	Time	Signed	Witnessed