Broadwindsor CE VC Primary School

CONSENT FORM FOR ADMINISTRATION OF MEDICINE/TREATMENT

Name of pupil ……

Home Tel No ……

Parents work Tel No ……

Mobile phone ……

The above named child has been identified as having:

……

Name of Medicine	Required Dose	Frequency/ Times	Course finish	Medicine expiry

Special instructions:

……

……

I agree to members of staff administering medicines/ providing treatment to my child as directed above or in case of emergency, as staff consider necessary.

I understand that I must deliver the medicine personally to the school office in the box/bottle provided by the chemist and accept that this is a service which the school is not obliged to undertake.

Signed……..Date……

Parent/Guardian