St Patrick's Catholic Primary School

Diocese of Portsmouth

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Headteacher: Mr Michael Lobo

CONSENT FORM FOR TREATMENTS/MEDICINES

CHILD'S NAME _____ Class: _____

DOB: _____

PARENT / CARER

Telephone Home: _____ Work: _____

Name of GP: _____ Tel Number: _____

Please tick appropriate box:

I agree to members of staff administering medicines for my child as detailed below: ☐

Signed: _____ Date: _____

I understand and accept that this is not a service that the school is obliged to provide.

Name of medicine	Dosage	Time to be administered	Completion date of course	Expiry date of medicine

Special instructions:
Allergies:
Other prescribed medicines for child:
Procedure to be taken in an emergency:

ALWAYS ASK ANOTHER ADULT TO CHECK AND COUNTERSIGN

Date	Time	Medicine given	Dose	Signature	Signature

RECORD OF PRESCRIBED MEDICINES GIVEN TO CHILD IN SCHOOL:

CHILD'S NAME: **CLASS:**