Westfield Junior School

ADMINISTRATION OF MEDICATION CONSENT FORM

NAME OF CHILD	
DATE OF BIRTH	
CLASS TEACHER	
NAME OF PARENT/CARER	
HOME TELEPHONE NUMBER	
WORK TELEPHONE NUMBER	
NAME OF GP	
GP'S TELEPHONE NUMBER	

I consent to my child being administered the following medication in school:-

NAME OF MEDICINE	REASON REQUIRED
a)	
b)	
c)	

I will make sure that the school has sufficient stock of medication for daily administration.

I understand that the School cannot accept responsibility for pupils bringing medication into School for self-administration.

I will ensure that my child knows how and when he/she should take his/her medication.

I will inform the School if my child's circumstances change, e.g. different medication, or treatment no longer required.

Signed ..... *Parent/Carer* Date .....