BIGGIN HILL PRIMARY SCHOOL
ADMINISTRATION OF MEDICINES AND TREATMENT CONSENT FORM

NAME OF CHILD	
ADDRESS	
PARENT/CARER	
CONTACT NUMBERS	: :
NAME OF G.P	
G.P CONTACT NUMBER	

Please tick the appropriate box:

My child will be responsible for the self-administration of medicines as directed below	
I agree to a member of staff administering medicines/providing treatment to my child, as directed below:	
I recognise that staff are not medically trained.	
SIGNATURE OF PARENT/CARER	
DATE OF SIGNATURE	

NAME OF MEDICINE	REQUIRED DOSE	FREQUENCY	COURSE FINISH	MEDICINE EXPIRY

SPECIAL INSTRUCTIONS	

ALLERGIES	

OTHER PRESCRIBED MEDICATION	