CPS

Curwen Primary School
Together Everyone Achieves More

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CONSENT FORM FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION

Name of Child _____ **Class** _____

Date of Birth _____

Address _____ **post code** _____

Name of Parent / Carer _____

Tel No. Home _____ **work** _____

Child's General Practitioner _____

Address _____ **Tel no.** _____

Please give details below of the prescribed medication that your child requires

Name of medication	Dose required	Regularity required	Method –tablet or liquid form

Note: All medication must be clearly marked with the chemist prescription label and only then can we administer medicines.

Is your son / daughter responsible for taking their own medicine? YES / NO

I consent to a member of school staff administering my son / daughter's medication as prescribe by the GP.

Signed _____ **(parent / carer)** **Date** _____

Log of medication given

Date	Time	Given by	Signed