ADMINISTRATION OF MEDICINES/TREATMENT – FORM OF CONSENT

Robert le Kyng Primary School

Child's Name _____

Address _____

_____

_____

GP's Name _____ Home Tel no _____

GP's Tel No _____ Work Tel no _____

Mobile no _____

Long term Medication to be taken during the course of the school day
(If more than one medicine is taken, please request an additional form.)

Name of medicine	Dose	Frequency/times	Nature of Illness Date of completion of course (if known)

The information provided is accurate to the best of my knowledge at the time of writing and I give consent to the school to administer the medication in accordance with the LEA policy. I will inform the school in writing of any changes to the information.

Signed _____ Date _____

Allergies (eg peanuts / bee stings / hay fever)

If emergency treatment is required, an individual Healthcare Plan must be prepared in advance with the school nurse. Please contact the school immediately to arrange.

Other medical concerns (eg eyesight/hearing/eczema)