

Administration of Medicines & Treatment Consent Form

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| Name of School | Mill Rythe Junior School |
| Name of Child | |
| Address of Child | |
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| Parents' Home Telephone No. | |
| Parents' Mobile Telephone No. | |

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|---------------------------|--|
| Name of GP | |
| GP's Telephone No. | |

Please tick the appropriate box

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| My child will be responsible for the self-administration of medicines as directed below | |
| I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of emergency, as staff may consider necessary. I recognise that school staff are not medically trained. | |

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| Signature of parent or carer | |
| Date of signature | |

| Name of Medicine | Required Dose | Frequency | Course Finish | Medicine Expiry |
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| Special Instructions | |
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The administration of medicines detailed above will be recorded on the reverse of this form.

NB: The school will not administer aspirin or medicines containing ibuprofen, nor should children bring these into school for self medication.

