Administration of Medicines and Treatment Consent Form

Nightingale Primary School

Child's Name:	DOB: ……/……/……
Class:	Male/Female

Parents Contact Telephone Number	
Mobile Number (if different)	

Please tick the appropriate box:

My child will be responsible for the self-administration of medicine as directed below.	
I agree to members of staff, who have been appropriately trained, administering medicine/providing treatment as directed below.	

I recognise that staff are not medically trained.

Signature: ……

Print Name: …… (Parent/Carer with parental responsibility)

Date: ……

Name of Medicine	Required Dose	Time to be given	Duration to be given	Expiry Date

Any special instructions: ……

……

Any allergies or other prescribed medication: ……

……

Medicine signed in by: …… Date: ……

Medicine collected by: …… Date: ……

Added to Medication in School register ☐

Record of Prescribed Medicines Given to a Child in School

Name of School	Nightingale Primary School
Name of Child	
Class	
Date of Birth	……/……/……

Date	Time	Medication	Dose	Administered by
…/…/…	:			
…/…/…	:			
…/…/…	:			
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