Consent form for the administration of prescription drugs

Child's Name:		DOB	
Address:			
Parent Name:		Relationship	
Daytime Phone No:			
Procedures to be taken in an emergency:			
Name of Doctor			
Surgery Address			
Surgery Telephone Number			

LIST OF PRESCRIBED MEDICINES

Name of Medication and strength	Dosage	Frequency	Duration	Date to Commence
Any other Comments				

Doctor/Consultant Signature	Prescribers/Surgery Stamp

Please return to: Mrs K Burton, Student Services, Chilwell School, Queens Road West, Chilwell, Nottingham. NG9 5AL