Consent form for the administration of non-prescription drugs

THIS FORM MUST BE COMPLETED BY PARENT/CARER

If staff have any concerns discuss request with school healthcare professionals

Name of School/Setting:			
Child's Name:		DOB	
Registration Group:			
Address:			
Procedures to be taken in an emergency:			

List of Medicines (Medicines must be in original container/box with instructions and clearly named or as dispensed by a pharmacy)

Name of Medication and strength	Dosage	Frequency	Duration	Date to Commence

Contact Information

Parent Name:	
Daytime Phone No:	
Relationship to child:	

Signed: Date:

Please return to:

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