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| **Consent Form for the Administration of Medicines/Treatments** |

Child’s Name ………………………………………………. Class………..…

Address ……………………………………………………..................................

………………………………………………………………………..

Name of Parent/Carer ……………………………………………………………….……….

Day time contact number …………………………… Mobile………………………....

Name of child’s GP …………………………… Tel No…………………………

Please tick the statement below which is appropriate

My child will be responsible for the self-administration of medicines as directed below.

I agree to members of staff administering medicines/ treatment to my child as directed below or in the case of an emergency, as staff consider necessary

I wish to call in to school and administer my child’s medicines

Parent/Carer Signature ……………………………………… Date ……………………

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| --- | --- | --- | --- | --- |
| Name of medicine | Dose | Frequency/times | Completion date of course | Expiry date  of medicine |
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| Special Instructions | | | | |
| Allergies | | | | |
| Other prescribed medicines being taken by the child at home | | | | |

***Inspired by Him, we serve the community of St Michael’s by creating an inclusive learning culture where all differences are respected, where courage is shown to face and overcome adversity, and resilience is embedded in our journey to success so we can be the very best we can be.***

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| **Administration of Medicines/Treatments** |

Childs Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Date | Time | Medicine given | Dose | Signed |
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