CHILDREN’S SEVICES HEALTH & SAFETY

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| **Administration of Medicines & Treatment Consent Form** |

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| Name of School | **The Federation of Winklebury Infant and Junior Schools** |
| 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 |  |
| GPs Telephone No. |  |

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| --- | --- |
| My child will be responsible for the self-administration of medicines as described 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 |  |

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| --- | --- | --- | --- | --- |
| Name of Medicine & Strength | Required dose | Frequency | Course finish | Medicine expiry |
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| Special Instructions |  |
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| Allergies |  |
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| --- | --- |
| Other Prescribed Medicines |  |
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**RECORD OF PRESCRIBED MEDICINE GIVEN TO A CHILD**

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| --- | --- |
| Name of School / Setting | Winklebury Infant / Junior School |
| Name of Child |  |
| Registration Group of Child |  |
| Date of Birth of Child |  |

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| --- | --- | --- | --- | --- |
| Date | Time | Medicine Given | Dose | Signature |
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