**PARENTAL CONSENT FOR THE ADMINISTRATION OF PRESCRIBED MEDICINES**

My child …………………………………attended the doctor’s surgery on ………………………… and

has been diagnosed with ……………………………………………………………………….

My child has subsequently been prescribed …………………………………………………………..

I therefore ask, and give permission for, the school staff to administer the following:

Name of medicine …………………………………………………………………………………….

Date/time of previous dose given……………………………………………………………………

Dosage to be given …………………………………………………………………………………..

Time medicine should be given by member of staff:.…………………………………………….

Signed: ……………………………………………………

Dated: …………………………………………………….



**PARENTAL CONSENT FOR THE ADMINISTRATION OF PRESCRIBED MEDICINES**

My child ……………………………………..attended the doctor’s surgery on …………………… and

has been diagnosed with …………………………………………………………….………….

My child has subsequently been prescribed …………………………………………………………..

I therefore ask, and give permission for, the school staff to administer the following:

Name of medicine ………………………………………………………………………………………..

Date/time of previous dose given ………………………………………………………………………

Dosage to be given ………………………………………………………………………………………

Time medicine should be given by member of staff:………………………………………………

Signed: ……………………………………………………

Dated: …………………………………………………….