LYTCHETT MATRAVERS PRIMARY SCHOOL

CONSENT FORM FOR ADMINISTRATION OF MEDICINE/TREATMENT

CHILD'S NAME	
CHILD'S CLASS	
ADDRESS	
HOME TEL NO	
MOBILE NO	
GP'S NAME	
GP'S TEL NO	
MEDICAL CONDITION	
NAME OF MEDICINE	
DOSE REQUIRED	
FREQUENCY/TIME	
SPECIAL INSTRUCTIONS	

I agree to members of staff administering medicines/providing treatment to my child as directed above, or in case of emergency as staff consider necessary.

Signed ____
Parent/Guardian

Date ____