

Medication Consent Form

Child's Full Name

Name of childcare setting: Kinda Forest School

Child's Address:

Parent / Guardian E-mail Address:

Parent / Guardian contact number

Name of child's GP

Address of child's GP surgery

Contact number for child's GP

Signature of parent/carer

Please detail any Special instructions, allergies and any other medications your child is taking:

Please tick the following options:

- My child will be responsible for self-administration of medication as directed below.
- I hereby consent to members of staff administering medication and /or providing treatment to my child as directed or in the case of an emergency as staff may consider necessary. I recognise that staff are not medically trained.
- I agree to supply any required medication in accordance with the company medication policy.
- I agree to update this information as and when required.

Name of medication

Required dose

Time to administer

Frequency

Medication expiry date

Course finish date