



Office Use Only:
Date received _____
Copied to Arbor
Pupil folder
Original – Medication Folder
Please destroy all previous versions

Medication Information and Consent Form

Name Of Child	Forename(s):	Surname:
Date of Birth		
Address:		
Post Code:		

Contact Details	
Mother (name);	Father (name):
Home Tel No:	Home Tel No:
Work Tel No:	Work Tel No:
Mobile No:	Mobile No:

Details Of Child's Doctor	
Name:	
Address:	
	Tel No:

Guardian/Carer Details (if different to the above):	
Name(s):	Relationship to child:
Address:	
Tel No:	

Emergency Contact If Parent Is Not Available	
Name:	
Relationship to the child:	
Home Tel No:	
Work Tel No:	
Mobile No:	

Name And Address of Parent Who Does Not Have Custody:	
Name:	Relationship:
Address:	
Tel No.	

Current Medication (please give exact dosage and time taken during the 24 hour period)					
Medication		Dosage/time			
Medication		Dosage/time			
Medication		Dosage/time			
Medication To Be Given At School (medication to be kept at school and administered by trained staff)					
1. Condition requiring treatment					
Medication		Dosage		Time to be given	
Other action required					
2. Condition requiring treatment					
Medication		Dosage		Time to be given	
Other action required					
Any Other Special Medical Details (i.e. asthma, migraine, allergies, diet, specific conditions etc)					
1.					
2.					

EMERGENCY TREATMENT

I give permission for the school to administer medication and emergency treatment to my son/daughter/ward.

Should the necessity arise, I agree to the person in charge giving consent on my behalf for an anaesthetic to be administered or for any other urgent treatment to be given.

Signed: _____ Date: _____

Name: _____ Relationship: _____