GARDEN SUBURB JUNIOR SCHOOL
Childs Way, London NW11 6XU

MEDICAL CONSENT FORM

Child's Name: Class:
Parent/Carer's Name:
Address:
Telephone:
Emergency Contact Name:
Address:
Telephone:
Doctor:
Address:
Telephone:
Illness:
Medicine Prescribed:
Dosage:
Time to be given in School:
Any special instructions:
Any known allergy:

I agree to my child receiving the above medication as documented on this plan whilst in the care of education staff. I understand this is a service which the school is not obliged to undertake if appropriate information has not been supplied. I understand I am responsible for ensuring the appropriate medication is available to the school. I authorise the Children and Young People's Health Service to contact my GP to discuss if necessary. I confirm I am the parent/carer for the above child and I am able to give authority for the administration of the above medication.

Signed: _____ Date_____

Parent/Carer