



Medical consent form

Ysgol Gymraeg Cwmbrân



Request for the administer of prescribed medicine in school:

Parent/guardian name:

Child's name:

Child's date of birth:

Address:

.....

Contact number:

My child (named above) should receive:

Name of medicine: (as on container)

Expiry date (if known):

Dose of medicine:

Time of administration:

Duration of treatment:

Possible side-effects:

Signature: Date:

While every effort will be made to adhere to the doses and times noted above, the school will not be held responsible should any error occur. Should there be any doubts or queries in what is to be administered, no medicine will be given until we get satisfactory confirmation from the parent / guardian.

FOR OFFICE USE ONLY:

Date	Time	Dose	Signature	Date	Time	Dose	Signature