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Head Teacher: Mrs. P. Price, Cert. Ed.
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MEDICAL ADMINISTRATION CONSENT FORM

We are unable to administer medication unless consent is given through completion of this form.

Name of child	
Date of birth	/ /
Class	
Medical condition or illness	

Medicine

Name/type of medicine <i>(as described on the container)</i>	
Date dispensed	/ /
Expiry date	/ /
Dosage and method	
Timing	
Special precautions	
Are there any side effects that the school needs to know about?	
Self administration	Yes/No
Procedures to take in an emergency	

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	School Office

I accept that this is a service the school is not obliged to undertake.

I understand that I must notify the school of any changes in writing.

Date _____

Signature(s) _____

