

**MEDICAL CONSENT FORM**

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| --- | --- |
| Child’s Full Name |  |
| Child’s Address |  |
| Child’s Date of Birth |  |
| Details of Medical Condition i.e. what medicine/tablet is for |  |
| Name of medication |  |
| Name and contact details of prescriber |  |
| Dosage of Medication |  |
| Route for administration of medicine/tablet (circle which one) | ORAL (by mouth) TOPICAL (rub in) INHALEINJECTION  |
| Frequency of dosage or times to be given |  |
| Effective from Effective to | Date:Date: |
| Any other information e.g. side effects, potential adverse reaction or special precaution |  |
| How the medication is to be stored (as on directions given on medication label) |  |
| PRINTED Name of Parent/Guardian |  |
| \*\*Signature of parent or guardian authorising medication |  |
| \*\*Date |  |

N.B Parents or guardians, please read in full the criteria for the giving of medicines in this service which is at the back of this consent form

**Outcome record**

**(for temperature rechecks / whether tolerated / adverse or allergic reactions or other)**

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| **FULL NAME OF CHILD** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Time | Comment | Any Action Taken | Signature of Person |
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