Dove House School Academy

Dove House School
Administration of Medicines/Treatment

Child's Name:	
Address:	
Parents/Guardian Telephone:	Home: Work: GP:

Please tick the appropriate box

My child will be responsible for the self-administration of medicines as directed below: ☐

I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of an emergency, as staff consider necessary. ☐

Signed: ..... Date: .....
(Parent/Guardian)

Medication	Dose	Frequency/times	Completion date of course (if known)
Special Instructions:			
Allergies:			
Other prescribed medicines child takes at home:			