# Federation of St. Joseph's Junior, Infant and Nursery Schools
# Administration of Medicines Consent Form
# HEALTH CARE PLAN

| | | |
|---|---|---|
| Name of Child…….. | | |
| Class: | Gender: Male/Female | DOB: |
| Parents' Home Telephone No……<br>Parents' Mobile Telephone No…… | | |
| Name of GP…… | | |
| GP's Telephone No…… | | |

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|---|---|
| I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of emergency, as staff may consider necessary. | |
| Name of Medicine Required | Illness/Condition |
| Dose/Frequency : | Length of course of medication:……..days<br>Starting from:…… (date)<br>To: …… (date) |
| Information for staff about any triggers or symptoms. | |
| Special Instructions/Directions for an emergency | |

Date……..

Signature of parent or carer ……..