THE CAVENDISH HIGH ACADEMY
CONSENT TO TREATMENT

Name of Pupil ……..…… G.P. ……..……..……..

Date of Birth ……..…. Health Visitor ….……..……

Name of Parent/Guardian ……..……

Address ……..……

……..……..…

……..……..

Telephone ……

In the event of illness or emergency and we are unable to contact you please supply an alternative contact.

Name …….. Relationship to pupil ……..……...

Address ……..……

…….....

……..….

Telephone ……

Has your child any allergies? ……....

…….……..

…….……...…...

Complete this section if your child has regular medication or has medication that should be given in an emergency.

Home Medication **Amount** **Time**

……...…

…….……..

……..….

School Medication ……..…….

……

……

Emergency Medication Please be specific

Medication ……..…

When given ……..….

How ……...

AUTHORISATION – EVERYONE PLEASE READ AND SIGN BELOW

I authorise that a delegated member of staff may administer such drugs/treatment as prescribed by the doctor, for regular, occasional and/or emergency use.

I agree to this information being shared with other professionals if this should benefit my child and will notify any changes to regular or emergency drugs and procedures to the school.

Signature …… Date…….……..….