

**Consent to Administer Paracetamol in Special Schools**

Child's name:	DOB:
Address:	
GP's Name:	Tel No:
Allergies:	
Name of Parent/Guardian: (print)	
Relationship to child:	

**Child Consent** (where possible)

**I consent to the appropriately trained staff giving me medication.**

Child's signature:
Date:

<b>PARACETAMOL</b>	
Which strength:	Infant 120mg/5ml <input type="checkbox"/> 6 Plus 250mg/5ml <input type="checkbox"/> 500mg tablets <input type="checkbox"/>
Dosage:	HOW MUCH SHOULD BE GIVEN _____ Dose to be given orally by spoon/syringe/tablet. How often 4-6 hourly ( <b>Total 4 doses in 24 hours</b> )
Parent/Guardian signature:	_____
Print name:	_____
<b>I will provide my child's medication in its original container/packaging. I consent to the appropriately trained staff administering Paracetamol to my child.</b>	