Oxford Health NHS
NHS Foundation Trust

OXFORDSHIRE COUNTY COUNCIL
CHILDREN, YOUNG PEOPLE & FAMILIES
www.oxfordshire.gov.uk

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:

PARACETAMOL

Which strength:
- Infant 120mg/5ml ❑
- 6 Plus 250mg/5ml ❑
- 500mg tablets ❑

Dosage: HOW MUCH SHOULD BE GIVEN _____
Dose to be given orally by spoon/syringe/tablet.
How often 4-6 hourly **(Total 4 doses in 24 hours)**

Parent/Guardian signature: _____

Print name: _____

I will provide my child's medication in its original container/packaging. I consent to the appropriately trained staff administering Paracetamol to my child.