Consent to medical treatment in Children with Disabilities Services

Child's name ..... Date of birth .....

Name of GP ..... Tel .....

☐ I consent to trained staff providing first aid treatment to my son/daughter

OR

☐ I do not consent to trained staff providing first aid treatment to my son/daughter

Signed .....

Date .....

☐ I consent to staff arranging emergency medical examinations and treatment

OR

☐ I consent to staff arranging emergency medical examinations and treatment **with the exception of** the following (please specify the nature of the treatment and the reason for withholding of consent)

OR

☐ I do not consent to staff arranging emergency medical examinations and treatment (including dental examinations and treatment)

Signed .....

Date .....

☐ I consent to staff administering the following non-prescription medications supplied by me:

- ☐ Sun cream
- ☐ Painkillers/analgesics – specify .....
- ☐ Cough syrup – specify .....
- ☐ Cold remedies – specify .....
- ☐ Anti histamine – specify .....
- ☐ Calamine Lotion .....
- ☐ Holistic remedies – specify .....

(Please note that any prescribed medication will be subject to a separate consent)

Signed .....

Date .....

BEDFORD BOROUGH COUNCIL