ADMINISTRATION OF MEDICINES

The School will not give your child medicine unless you complete and sign this form, and the school has a policy that the staff can administer medicine.

Date for review to be initiated by	
Name of School	
Name of Child	
Date of Birth	
Class	
Medical condition or illness	

MEDICINE

Name/type of medicine *(as described on the container)*	
Expiry Date	
Dosage and Method	
Timing	
Special precautions / other instructions	
Are there any side effects that the school needs to know about?	
Self-administration - y/n	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy

CONTACT DETAILS

Name	
Daytime telephone number	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to:	Mrs Staff or Mrs Hammerton

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature …….. Date…….