PARENTAL CONSENT FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medication unless you complete and sign this form.

Pupil Details

Surname……..Forename……

Address……M/F……

…… DOB……

…… Class……

Condition or Illness……

Name of Medication and strength……

Date Dispensed……

Date of course completion……

Directions for use

Dosage (mg/ml)……

Timing……

Side Effects (if any)……

Procedures/Contacts in case of emergency

……

……

Contact details

Name……

Relationship to child……

Daytime Contact No……

Signature……

Date……

Staff accepting medication

Name……Date……

N.B. We are happy to administer antibiotics if children have been prescribed them 4 times a day.