



PERMISSION FOR ADMINISTRATION OF MEDICATION TO A PUPIL

THE SCHOOL WILL NOT GIVE YOUR CHILD MEDICINE UNLESS IT IS PRESCRIBED, KEPT IN ORIGINAL CONTAINER AND YOU HAVE COMPLETED AND SIGNED THIS FORM. THE PRINCIPAL MUST AGREE THAT SCHOOL STAFF CAN ADMINISTER THE MEDICATION.

Pupil details:

Surname: _____ Gender: _____
Forename(s): _____ Date of Birth: _____
Address: _____

Condition or illness: _____

Medication:

Name/type of medication (as described on the container): _____
For how long will the child need to take this medication: _____
Date dispensed: _____

Full Directions for use:

Dosage and method of administration: _____
Time(s) of administration: _____
Special precautions: _____
Side effects: _____
Procedures to take in an emergency: _____

Contact Details:

Name: _____ Daytime contact No: _____
Relationship to pupil: _____ Mobile: _____
Address: _____

I understand that I must deliver the medicine personally to an agreed member of staff and accept that this is a service, in which the school are not obliged to undertake.

Date: _____ Signature: _____

Relationship to child: _____ Print name: _____



