



Willow Tree
Primary School



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: _____ Class/Year: _____

Condition or Illness: _____

Medication:

Name/type of medication (as described on the container) _____
For how long the child will 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: _____
Relationship to pupil: _____
Daytime contact No: _____

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.

Signature: _____ **Date** _____



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