

## MEDICATION IN SCHOOL

This form is to be completed and signed before any medication will be administered by school staff.

Child's Name: \_\_\_\_\_

Child's Class: \_\_\_\_\_

Child's Medication: \_\_\_\_\_

Name of Prescribing Doctor: \_\_\_\_\_

Storage/Preparation details: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time of Dosage: \_\_\_\_\_

Timescale for medicine to be administered: \_\_\_\_\_

Parents Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

I give permission to staff to administer medication according to the details above.

I understand that staff cannot fully guarantee that medication will be administered exactly as above and that in this event staff cannot be held responsible for any adverse consequences.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Please hand in the form and medicine to your child's teacher or the school office