MEDICATION FORM

The school will not give your child medicine unless you complete and sign this form and the Headteacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL:

Surname		**Forenames**	
Date of birth		**Class**	
Address		**Condition/ illness**	

DETAILS OF MEDICATION:

Name of medication	
For how long will your child take this medication	
Date dispensed	
Dosage and method	
Timing	
Self-administer (please tick one box)	**Yes ☐ No ☐**
Procedures to take in case of emergency	

CONTACT DETAILS:

Name	
Telephone number	
Signed	
Date	

You may withdraw your consent at any time by informing the school in writing