

NORDEN COMMUNITY PRIMARY SCHOOL

PARENTAL PERMISSION TO ADMINISTER MEDICATION IN SCHOOL

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: _____

Forename(s): _____

Address: _____

Male/Female: _____

Date of Birth: _____

Class/Form _____

Condition or illness: _____

MEDICATION

Name/Type of Medication (as described on the container) _____

For how long will your child take this medication: _____

Date dispensed: _____

Full Directions for use:

Dosage and method: _____

Timing: _____

Special Precautions: _____

Side Effects: _____

Self Administration: _____

Procedures to take in an Emergency: _____

CONTACT DETAILS:

Name: _____ Daytime Tel No _____

Relationship to Pupil: _____

Address: _____

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

Date: _____ Signature _____