

PARENTAL CONSENT FOR SCHOOL/CENTRE TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this Form or have Form 1A completed by your GP.

Details of Pupil

Surname..... Forenames(s).....

Address M/F

..... Date of Birth.....

..... Class/Form

Condition or Illness

Name/Type of Medication (as described on container)

For how long will your child take this medication?

Date dispensed

Full Directions for Use

Dosage

Timing

Special Precautions

Side Effects

Self Administration

Procedures to take in an Emergency

.....
.....

Contact Details

Name Daytime Telephone No

Relationship to Pupil

Address

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

Date Signature(s)

Relationship to Pupil

[illegible]