



ADMINISTRATION OF MEDICINES

Name of Pupil: _____

Class: _____

Address: _____

Medical condition

of Pupil: _____

Medication: _____

Dose: _____

Frequency of dose: _____

Please indicate if medicine should be:

- a) Taken with water
- b) On an empty stomach
- c) With food
- d) At a particular time e.g. 1 hour before food etc.
- e) Please inform of any other requirements: _____

I confirm that I give my permission for the Headteacher (or his/her nominee) to administer the medicine to my son/daughter during the time he/she is at school.

Signed: _____ **Parent/Guardian**

Date: _____

The school will make every effort to provide this service; should any circumstances prevent the school from doing so, the school will inform the named contact at once, so that alternative arrangements can be made by the parents.

The school agrees to the administration of the medicine as detailed above.

Signed: _____ **(Headteacher/agreed staff member)**

Date: _____