Administration of Medicines Form

Staff will not administer medicines to your child unless this form is completed and signed.

Student Details

Name of student	
Date of birth	
Tutor group	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Date dispensed	
Expiry date	
Dosage instructions	
Are there any side effects that the school needs to know about?	
Medicine to be self-administered?	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy.

I understand that I must inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature ____**Date** ______________

Name	
Daytime telephone number	
Relationship to student	