

LEES HILL C OF E SCHOOL



PARENTAL PERMISSION FOR SCHOOL STAFF TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this Form, and the Headteacher has agreed that school staff who volunteer to do so can administer the medication.

DETAILS OF PUPIL

Surname: _____
Forename: _____
Address: _____ M/F: _____
Date of Birth: _____
Class/Form: _____
Condition or illness: _____

MEDICATION

Name and strength of Medication (as described on the container): _____
Form (e.g tablets, syrup, cream) : _____
For how long will your child take this medication? _____
Date dispensed by doctor/pharmacist: _____

Full directions for use:

Dosage and method to be taken: _____
Timing: _____
Special precautions: _____
Details of any side effects: _____
Can your child self administer? (See Appendix C in SAN(M)1 _____
Procedures to take in an Emergency: _____

CONTACT DETAILS

Name: _____ Daytime Telephone No: _____
Relationship to pupil: _____
Address (if different to above): _____

I understand that I must deliver the medicine personally to _____ (agreed Member of staff) and accept that this service is provided by the relevant member of staff and the school on a voluntary basis. I agree to inform the school of any changes to this information by completing a new form at the earliest opportunity.

Date: _____ Signature: _____

Relationship to Pupil: _____