

Consent for the administration of medicine

Pupil’s name …………………………………………………………………..………………..

Form …………………………………………………………………………………….

Reason for medication …………………………………………………………………………………….

Name of medication …………………………………………………………………………………….

Dosage & times

medication must be given …………………………………………………………………………………….

I have given my daughter this medication before with no side-effects

Please ensure the medication is clearly marked with your daughter’s name and handed into the school office.

It is your responsibility to collect the medication from the office each evening.

Signed …………………………………………………….. Date …………………………