Appendix 4

Garfield Primary
Today's children, tomorrow's future.

Administering Medication Permission Form
Asthma pumps

Date:_____

Child's Name: Class:

_____

Name and strength of Medication: Expiry Date:

Dosage to be given:

_____

Start of Prescription:

_____

End of Prescription:

_____

GP's Name: GP's Telephone Number :

_____

Name of Parent/Carer: Daytime Phone number:

_____

Agreed review date to be initiated by: _____ (Name of member of staff)

The above information is to the best of my knowledge accurate at the time of writing and I give consent to the school staff administering medicine in accordance with the school policy. I will inform the school setting immediately if there is any change to the frequency or dosage of the medication or if the medication is stopped. I will ensure the medication is not out of date.

Name of Parent/Carer: _____ Signature of Parent/Carer: _____

Date:_____

Information checked by : _____ Date:_____

COPY TO BE GIVEN TO PARENT

Appendix 4