Appendix 3

Administering Medication Permission Form

Date:________________

Child's Name: Class:

____

Name and strength of Medication: Expiry date:

____

Time of Last Dose:

____

Time to be given in school:

____

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 I will ensure the medication is not out of date.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 3