**PERMISSION TO ADMINISTER MEDICINE TO AN INDIVIDUAL CHILD**

Student Name: Tutor Group:

Address:

Parent/Carer Contact Telephone Number:

Name and Address of GP:

GP Telephone Number:

[ ]  I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of an emergency, as staff may consider necessary.

[ ]  I recognise that school staff are not medically qualified.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name (& Strength) of medicine** | **Dose** | **Frequency/Time to be given e.g. 11am** | **Completion date of course (if known)** | **Expiry date of medicine** | **Quantity of medicine given to school** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Special Instructions (e.g. keep in fridge)

Permission granted to use school inhaler if necessary?

Is your child taking any other prescribed medicines?

Signed (Parent/Carer): Date: