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)

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Permission granted to use school inhaler if necessary? ☐ **YES** ☐ **NO**

Is your child taking any other prescribed medicines? ☐ **YES** ☐ **NO**

If YES, please state: .....

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Signed (Parent/Carer): ..... Date: .....