Knowsley Lane
Primary School

PERMISSION FOR ADMINISTRATION OF MEDICATION TO A PUPIL

THE SCHOOL WILL NOT GIVE YOUR CHILD MEDICINE UNLESS IT IS PRESCRIBED, KEPT IN ORIGINAL CONTAINER AND YOU HAVE COMPLETED AND SIGNED THIS FORM. THE PRINCIPAL MUST AGREE THAT SCHOOL STAFF CAN ADMINISTER THE MEDICATION.

Pupil details:

Surname: _____ Gender: _____
Forename(s): _____ Date of Birth: _____
Address: _____ Class/Year: _____
_____
_____

Condition or illness: _____

Medication:
Name/type of medication (as described on the container): _____
For how long will the child need to take this medication: _____
Date dispensed: _____

Full Directions for use:
Dosage and method of administration: _____
Time(s) of administration: _____
Special precautions: _____
Side effects: _____
Procedures to take in an emergency: _____

Contact Details:
Name: _____ Daytime contact No: _____
Relationship to pupil: _____ Mobile: _____
Address: _____
_____
_____

I understand that I must deliver the medicine personally to an agreed member of staff and accept that this is a service, in which the school are not obliged to undertake.

Date: _____ Signature:_____

Relationship to child: _____ Print name: _____

For Office Use Only:

Administration of Medication Record for …… (Pupil's Name), in Year…….. (Class)

Date	Name of Medication - as stated on prescription sticker	Dosage	Time Due	Time Given	Any Reaction Noted	Administered By		Witnessed By	
						Print	Sign	Print	Sign