MEDICATION CONSENT & ADMINISTRATION FORM: PRESCRIBED MEDICATION

The school/setting will not give your child any medication unless you complete and sign this form and the Head Teacher has confirmed that school staff have agreed to administer the medication.

DETAILS OF PUPIL

Surname: .....

Forename (s): .....

Class: .....

Reason for medication (optional): .....

MEDICATION

Name/Type of Medication (**as described on the container)** .....

Time of last dose administered off site: .....

Dosage to be taken in school: .....

Duration of the course of medication **(up to one week)** .....

Date: .....

Signed: .....

MEDICATION ADMINISTRATION TO BE COMPLETED BY SCHOOL STAFF

		1st adult		2nd adult	
Date	Time	Signed	Print name	Signed	Print name