MEDICATION FORM

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

Name of school/setting	CLEVES				
Name of child					
Date of birth					
Group/class/form					
Medical condition or illness					
Medicine					
Name/type of medicine *(as described on the container)*					
Expiry date					
Dosage and method					
Timing					
Special precautions/other instructions					
Are there any side effects that the school/setting needs to know about?					
Self-administration – y/n					
Procedures to take in an emergency					
NB: Medicines must be in the original container as dispensed by the pharmacy					
Contact Details:					
Name					
Daytime telephone no.					
Relationship to child					
Address					
I understand that I must deliver the medicine personally to	Mrs Lockyer or Class teacher				

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s)_____ Date_____