



CHILDS NAME:	DOB:	FORM:
Name of Medication:		
Reason:		
Dosage:		
How often, when to be given:		
Finish date:		
Any other instructions (eg. take with food/on empty stomach)		

Medication will be administered by the School Nurse or a member of school staff.
I understand that it may be necessary for this treatment to be carried out during educational visits
and other out of school activities, as well as on the school premises.

Telephone number of parent or adult to contact: _____

Name of Doctor: _____ **Tel No:** _____

To be completed by the School Nurse or member of staff.

[illegible]