

SCHOOL MEDICINE FORM

To be completed by the parent/guardian. If more than one medicine is to be given, a separate form should be completed for each.

CHILDS NAME:	ΛE:				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)											
Medicines must be supplied in their original packaging, with the prescription label attached stating the child's name, medication name, dose and expiry date. Parents should hand medicines in and collect at the end of the day from the School Office. 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.											
Signed:Par					nt/Guardian) Date:						
Telephone number of	parent	or adu	It to co	ntact: .							
Name of Doctor: Tel No:											
To be completed by the School Nurse or member of staff.											
DATE											
DOSAGE											
TIME GIVEN											
SIGNATURE											