SKYSWOOD PRIMARY & NURSERY SCHOOL

CONSENT TO ADMINISTER MEDICINES

The school staff will not give any medication unless this form is completed and signed.

Dear Headteacher

I request and authorise that my child:

Name _____ Date of Birth _____

Address _____

_____

Phone No _____ Class _____

be given the following medication/gives himself/herself (delete as appropriate) the following medication:

Name of Medicine _____

Time of Dose _____ Dose _____

Start Date _____ Finish Date _____

This medication has been prescribed for my child by:

Name of GP: _____ ,
whom you may contact for verification.

I have confirmed that it is necessary to give this medication during the school day.

The medication must be in the original container indicating the contents, dosage and child's full name.

Signed _____ (parent/carer)

Date _____