PARENTAL AGREEMENT FOR ADMINISTERING MEDICINE AT THE CROFT PRIMARY SCHOOL

Name of Child	
Date of Birth	
Year Group	
Medical Condition or Illness	

Medicine

Name/Type of Medicine	
Expiry Date	
Dosage & Method	
Timing	
Special Precautions/Other Instructions	
Self Administration Y/N	

MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY

PLEASE TURN OVER

GP Details

Name	
Telephone Number	

Contact Details

Name	
Daytime Telephone Number	
Relationship to Child	
Address	
Signed and Dated	

Please ensure this form is handed into the School Office in person