 **CROXBY PRIMARY SCHOOL**

 **PERMISSION TO DISPENSE MEDICINE**

**The school will not give your child medicine unless you complete and sign this form.**

**Administration of medication form**

Name of child:

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|  |

Date of birth:

Group/class/form:

Medical condition or illness:

**Medicine**

Name/type of medicine

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| --- |
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|  |
|  **Yes - No Time:**  |
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|  |
|  |
|  |

(as described on the container):

Expiry date:

Has the medication already been given today?

Dosage and method:

Timing (add 1 time only)

Special precautions/other instructions:

Any side effects that the school needs to know about:

Procedures to take in an emergency:

**NB: Medicines must be in the original container as dispensed by the pharmacy Contact details**

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|  |
| **The school office** |

Name:

Daytime telephone number:

Relationship to child:

I understand that I must deliver the medicine personally to:

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_