**Administration of Medicines**

Name of Child:

Name of Parent:

Home Contact Number:

Mobile Contact Number:

Name of GP:

GP Contact Number:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medicine** | **Dose** | **When (day and time)** | **Special Instructions** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Details of Allergies:

Details of other prescribed medication my child is currently taking:

Please tick:

□ My child will be responsible for administering the medication detailed above.

□ I agree to members of school staff administering the medication detailed above to my child. I understand that school staff are not medically trained.

I confirm I have parental responsibility for the child named above.

Signed: Date: