EWELL GROVE PRIMARY AND NURSERY SCHOOL
29 West Street, Ewell, Surrey KT17 1UZ
020 8393 4393

ADMINISTERING PRESCRIBED MEDICATION TO A PUPIL

Childs Name: .... Class: ……………………………………

Date of Birth: ....

Parent's surname if different: ....

Home Address: ....

Condition or Illness: ....

Parents Home Telephone no:...

Parents Work / Mobile no: ....

Name of GP who prescribed the medicine: ....

GP Telephone no: ....

Please tick the appropriate box:

☐ I confirm that the stated medicine has been prescribed by a GP for my child.

☐ My child will be responsible for the self-administration of medicines as directed below.

☐ I agree to members of staff administering medicines/providing treatment to my child as directed below.

Name of medicine	Dose	Approx time of dose	Completion date in School of course if known	Expiry date of medicine
Special precautions/other instructions:				
Side effects/ allergies:				
Other prescribed medicines child takes at home:				

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Ewell Grove staff administering medicine in accordance with the school's policy. I will inform Ewell Grove Primary & Nursery School immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signed: Date:

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Date	Name	Time	Amount Given