



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	Frequency or times	Completion date 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:

