



STEPPS PRIMARY & NURSERY CLASS
ADMINISTRATION OF MEDICINES PERMISSION FORM



The school will not give your child medicine unless you complete and sign this form, and the Head Teacher has agreed that school staff can administer the medicine.

Details of Pupil:

Surname: _____ Forename(s): _____

Address: _____

Date of Birth: _____ M F

Class: _____ School Session: _____

Condition or illness: _____

Medication

Name/Type of Medication (*as described on the container*)

For how long will your child take this medication? _____

Date dispensed: _____

Full Directions for use: _____





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Dosage and method: _____

Timing: _____

Special precautions: _____

Side effects: _____

Has the first dosage of the medicine been administered at home? Yes No

Please note, the first dosage MUST be administered by a parent/carer at home to ensure your child does not have any adverse reactions.

Does the medication need to be kept in a fridge? Yes No

Procedures to take in an emergency, or if your child refuses to take their medication:

Parents/carers must ensure that in date, properly labelled medication is supplied.

I understand that I must deliver the medicine personally to the school office and accept that this is a service which the school is not obliged to undertake.

Signature: _____ Date: _____

Relationship to pupil: _____

