REEPHAM PRIMARY SCHOOL

The school are only able to administer medicine once this form has been filled out and signed.

Name of School Reepham Primary School

Name of Child _____

Date of Birth _____

Year/Class _____

Medication condition of illness _____

Medicine

Name/type of Medicine _____

(as described on the container) _____

Expiry Date _____

Dosage and Method _____

Timing _____

Special precautions/other instructions _____

Are there any side effects 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

Name _____

Daytime telephone No. _____

Relationship to child _____

Address _____

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 the designated 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 and frequency of the medication or if the medicine is stopped.

Signature(s)_____ Date _____