

## Permission for Administering Medicines



<b>Pupil's Name:</b>		<b>Form:</b>	
<b>Name of Medication:</b>		<b>Expiry date:</b>	
<b>Dose:</b>		<b>Time (s):</b>	
<b>Date to be given from:</b>		<b>Date to finish:</b>	
<b>Treatment for:</b>	<b>Storage requirements (room temperature/fridge):</b>		
<b>Possible side effects:</b>			
<b>Any additional information:</b>			

	Please initial
I understand medicines need to be in their <b>original container with prescription label</b> , if applicable	
I understand my child will be supervised when administering medications wherever possible	
I undertake to collect medicines from school promptly when required to do so	
I undertake to ensure that all medication kept at school for my child is 'in date'	
<b>Asthma</b> – if my child's inhaler is unavailable, I give consent to an emergency inhaler being given to my child	
<b>Anaphylaxis</b> – if my child's EpiPen is unavailable I give consent to an emergency EpiPen to be used for my child	
I agree / do not agree to staff applying sun cream to my child <b>(Pre-Prep children only)</b>	

<b>Name of Parent:</b>			
<b>Signature of Parent:</b>		<b>Date:</b>	

I give permission for my child to administer his/her own medicine and he/she has signed below to show that he/she understands that medicine will be kept securely, administered according to the prescription and that it must not be given to another child <b>(Prep children only)</b>		
<b>Signature of child:</b>		<b>Date:</b>

<b>Signature of member of staff receiving medicine:</b>	
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