Permission for Administering Medicines

Pupil's Name:		**Form:**	
Name of Medication:		Expiry date:	
Dose:		Time (s):	
Date to be given from:		To:	
Storage requirements (room temperature/fridge):			
Possible side effects:			
Any special instructions:			

	Please initial
I understand medicines need to be in their **original container with prescription label**, 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'	
Asthma – if my child's inhaler is unavailable I give consent to an emergency inhaler being given to my child	
Anaphylaxis – 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 ***(Pre-Prep children only)***	

Name of Parent:		
Signature of Parent:		Date:

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 *(**Prep children only**)*		
Signature of child:		Date:

Signature of member of staff receiving medicine:	