

**MEDICATION TO BE ADMINSTERED AT SCHOOL**

* Name of Pupil…………………………………………………
* Date of Birth…………………………………………………..
* Class…………………………………………………………..

Medical conditions.

Medication to be administered.

* Medication name & type (Liquid/tablets) :
* Dosage :
* Time :

Is this medication: Please tick

Short Term Use. \_\_\_\_\_\_\_\_\_\_ Long Term Use. \_\_\_\_\_\_\_\_\_\_

Side effects with medication - Please give details if any below.

Please Tick – Is this medication to be kept in school \_\_\_\_\_ returned home daily \_\_\_\_\_\_

Signature of Parents/Carers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date form completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_