MEDICATION FORM

PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER

MEDICINE IF NECESSARY

Please note that all medication must be in the original packaging. In accordance with Department Of Health Guidelines we are unable to administer aspirin based medication to Students under 16 years of age unless it has been prescribed by a Medical Practitioner and we have evidence to support this.

CONTACT DETAILS

Student's Full Name: ________________________________ Tutor Group: _____________

Parent/Guardian Name (Please Print): ____

Relationship to Student: ______________________ Telephone No: ___________________

MEDICAL CONDITIONS - Does your child suffer from any medical conditions?

Please Specify:

Does your child take any regular medication **at home** (if so please give details below):

Name Of Medication	Dosage	Frequency/Times Taken
Details of me	dication	taken at home

MEDICATION TO BE HELD IN SCHOOL

If you require us to hold medication in school for a student, please complete the section below. This includes Paracetamol to be held for occasional use e.g. headaches/stomach aches etc.

1. Name of Medication: ____

Date Treatment Started (If Applicable): _____/_____/_____Expiry Date: _____/______

Any Other/Special Instructions: ____

2. Name of Medication: ____

Date Treatment Started (If Applicable): _____/_____/_____Expiry Date: _____/______

Any Other/Special Instructions: ____

I will deliver the medicine with this completed form personally to Student Reception and collect any remaining medication when the course is finished or medication has expired. I accept that the school has the right to refuse to administer medication. I understand that I must notify the school of any changes to the above in writing.

Signed: ___________________________ Date: ____________________________