



Cringleford CE VA Primary School - Medicine Consent Form

Medicines must be in the original container as dispensed by the pharmacy clearly showing the prescription label

I request that my child _____ in class _____

Be given the following medication :

Name of medication _____

Reason for medication _____

Expiry date _____

How much to give (dose to be given) _____

Time to be given _____

From _____ for a period of _____ days

Number of tablets/
qty given to school/setting _____

Does this need to be refrigerated ? Yes No

Child to self medicate Yes No

If yes, is teacher supervision required Yes No

Daytime phone no of parent or adult
Contact _____

Name and phone no of GP _____

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to 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 or frequency of the medication or if the medicine is stopped. I understand the conditions under which the school agrees to administer the medicine.

Parent Signature : _____ Print Name : _____

