ADMINISTRATION OF MEDICINE IN SCHOOL

No medication, including painkillers, can be administered to your daughter before this form is completed and returned to the School Office with medicine

Student's Name:	**Tutor Group:**

PRO FORMA:

I, _____ Parent / Guardian of the above student would like medication administered to my daughter.

☐ I give permission for this medication to be administered to my daughter

☐ I understand and accept that this is a service which the school is not obliged to undertake

Signed: _____ (Parent/Guardian) Date:_____

CONDITION OR ILLNESS THAT WILL BE MEDICATED

If your daughter 's medical condition changes would you please inform us in writing immediately.

☐ Please tick here if you are providing pain relief medication (eg. paracetamol) for **general pain relief**

MEDICATION:
Name / Type of medication:
How long will your daughter take this medication?
Date provided to School Office:

DIRECTIONS FOR USE:
Dosage:
Timing:
Special Precautions:
Side Effects: