Buckland Primary School

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Headteacher: Mrs Rebecca Hutton

PUPIL MEDICINE ADMINSTRATION FORM

CHILD'S NAME: _____ DOB_____

PARENT'S SURNAME (if different) _____

PARENT'S CONTACT NUMBER: _____

CONDITION OR ILLNESS: _____

GP Name:_____ Location:_____

Please tick the appropriate box:

☐ My child will be responsible for the **self administration** of medicines as directed below.

☐ I agree to members of **staff administering** medicines to my child as directed below.

- I agree to update information about the child's medical needs held by the school and that this information will be verified by relevant GP.
- I will ensure that the medicine held by the school has not exceeded its expiry date.
- I recognise that school staff are not medically trained.

MEDICINE NAME	DOSE	FREQUENCY	COURSE COMPLETION	EXPIRY DATE

Special Instructions_____

Signed (Parent/Carer)_____ **Date** _____