Sydenham Primary School
Medication in School

This form is to be completed and signed before any medication will be administered by school staff.

Child's Name: _____

Child's Class: _____

Child's Medication: _____

Name of Prescribing Doctor: _____

Storage / Preparation Details: _____

_____

Dosage: _____

Time of Dosage: _____

Timescale for medicine to be administered: _____

Parent's Name: _____

Contact Telephone Number: _____

I give permission for staff to administer medication according to the details above.

I understand that staff cannot fully guarantee that medication will be administered exactly as above, and that in this event staff cannot be held responsible for any adverse consequences.

Signed: _____

Date: _____

Please hand this form and the medicine (clearly marked with your childs name) to your child's class teacher or the school office.

Office Use

Date							
Time Administered							