Childs Name	
Date of Birth	
Year Group	
Medical Diagnosis / Condition	
Date	

Family Contact Information

Name	
Phone Number (Landline)	
Phone Number (Mobile)	
Name	
Phone Number (Landline)	
Phone Number (Mobile)	

Clinic / Hospital Contact

G.P Name	
Practice Name	
Phone Number	

Describe medical needs / condition and give details of child's symptoms

Describe what constitutes an emergency for the child, and the action to take if this occurs

Parental agreement for school to administer medication (long-term)

The school will not give your child medicine unless you complete and sign this form. You are also agreeing that school staff can administer medication at the agreed times and dosage on school trips/visits.

Child's Name	
Date	
Year Group	

Name of Medication	Dosage	Frequency/times	Number of tablets given to school	Expiry of medication

Any other instructions:

Note: Medication must be in the original container and dispensed by the pharmacy

Please tick appropriate box:

My child will be responsible for the administration of his own medication as above ☐

I agree to members of the school staff administering medication for my child as detailed above ☐

The above information is, to the best of my knowledge, accurate at the time of writing. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Parent Signature Date