**The school will not give your child medicine unless you complete and sign this form.**

|  |  |
| --- | --- |
| Name of Child |       |
| Date of Birth |       |
| Class Name |       |

*Antibiotics will only be given if they are prescribed* ***4*** *times a day. Medicines will be administered at lunchtime only. We would ask you to bear this in mind when planning the timings of your child’s medicine at home – thank you.*

|  |
| --- |
| Prescribed medicines must be in the original container as dispensed, dated and labelled by the pharmacy. Over the counter medicines must be in date, named & labelled with instructions for administration, dosage & storage. |
| Name of Medicine |       |
| Expiry Date |       |
| Date(s) medicine to be administered at school |       |
| Time medicine to be administered at school |       |
| How much to be given i.e. dose/tablets |       |
| Time medicine last administered at home |       |

|  |  |
| --- | --- |
| Name of GP |       |
| GP Telephone Number |       |

|  |  |
| --- | --- |
| SIGNED (PARENT/GUARDIAN) |       |
| DATE |       |