**PLEASE COMPLETE THIS FORM IF YOU WISH YOUR CHILD TO RECEIVE MEDICINES IN SCHOOL.**

**(PLEASE FILL IN ONE SHEET PER MEDICATION)**

## Details of pupil

Surname___________________________________________________________

Forename/s ________________________________________________________

Date of birth _______________________________________________________

Address____________________________________________________________

__________________________________________________________________

__________________________________________________________________

## Directions for use

Name of medicine __________________________________________________

__________________________________________________________________

Dose ______________________________________________________________

Route e.g. Oral, Gastrostomy________________________________________

Time to be given ___________________________________________________

Special precautions ________________________________________________

__________________________________________________________________

__________________________________________________________________

Signed Parent/Guardian _____________________________________________

Date _______________________________________________________________