Permission to Administer Medicine

Cherry Garden Primary School

Child's Details

Name of child:	Year Group:	Date of birth:

Details about the Medication

Name of medication:	Dose required:
	Time(s) to administer:

How long are you requesting we administer the medication for?

Date of first dose:	Date of last dose:

Give a brief description of why your child requires this medication.

Is the medication prescribed?	**YES**	**NO**
If NO please read and confirm: Best practice says that all non-prescription medication should be purchased from a pharmacist and contain a pharmacist's label on the packaging and bottle. Whilst we will administer medicines not purchased from a pharmacist, please indicate that you are taking full responsibility for this decision.	**YES**	**NO**
Is your child taking any other prescribed / non prescribed medication? If 'YES' please give details:	**YES**	**NO**

Are you aware of any side effects your child may experience by taking the medication?	**YES**	**NO**
If 'YES' please list these below:		

Confirmation of permission

I give permission for Cherry Garden Primary School to administer the above medication to my child. The information I have provided on this form is accurate and correct.		
Name:	Signed:	Date: