



St. Peter's C of E (V C) Primary School
Sible Hedingham, Halstead, Essex, CO9 3NR

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CONSENT FOR SCHOOL TO ADMINISTER MEDICATION

Pupils name _____ Class _____

Pupils Address _____

Condition/illness	
Name/type of medication	
Date treatment started	
Frequency of dose	
Timings	
Quantity	
How long will medication be taken	
Storage instructions (e.g. In fridge)	
Additional information. (e.g. before food)	

1st EMERGENCY CONTACT DETAILS

Name _____

Relationship to child _____

Contact number _____

2nd EMERGENCY CONTACT DETAILS

Name _____

Relationship to child _____

Contact number _____

I understand that I must deliver the medicine personally to the school office and collect any remaining medicine when the course is completed. I accept that the school has the right to refuse to administer medication.

Name _____

Relationship to child _____

Signed _____

Date _____