

School can only administer medicines prescribed by your GP

MEDICATION AT SCHOOL

THIS FORM IS TO BE COMPLETED BY THE PARENT OF ANY CHILD REQUIRING MEDICATION OF ANY FORM (or the use of an inhaler) PRIOR TO USE. Please tick box(es) as required.

CHILD'S NAME _____ FORM _____

This is to certify that the above named child requires:-

NAME OF MEDICINE _____ INHALER

DOSAGE _____ TIME _____

METHOD _____

I hereby nominate the:- WELFARE ASSISTANT CHILD NAMED ABOVE

To administer / self administer the prescribed medication as per these instructions.

I accept full responsibility for the accuracy of this listed information.

SIGNATURE _____ (Parent / Guardian)

A NEW FORM TO BE COMPLETED EACH TERM FOR CONTINUATION OF MEDICATION

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