The Academy will not give your child medicine unless you complete and sign this form. The Academy is not obliged to undertake this service.

All medication must be in the original box.

DETAILS OF PUPIL

Surname:_____ M/F:_____

Forename(s)_____ DOB:_____

Address:_____

_____

Condition/Illness_____

MEDICATION

Name/Type of Medication (as described on the container)_____

_____

Prescription / Over the Counter (please delete)

For how long will your child take this medication:_____

Expiry Date:_____

Full Directions for use:

Dosage:_____

Timing:_____

Special Precautions:_____

Will they need help to take the medicine:_____

CONTACT DETAILS:

Name:_____ Daytime Telephone No_____

Relationship to Pupil_____

Date:_____ Signature(s):_____

Executive Headteacher: Mrs S Paine MA NPQH
Chief Executive Officer: Mr S Gardner BA (Hons) MSc NPQH NLE

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