



Temporary Administration of Medicines

Child's Name:

Date of Birth: Year/Class:

Condition or Illness:

Parents' Tel:

G.P. Name: Tel:

Special Instructions:

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Allergies:

Other prescribed medicine child takes at home:

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Medicine to be Administered:

Name of Medicine	Dose	Frequency/Times	Completion Date of Course

I agree to members of staff administering medicines/providing treatment to my child as directed above. I accept full responsibility for the instructions provided and understand that, while every care will be taken to administer medication as instructed, staff will accept no responsibility for any mistakes.

Signed: Date:
Parent/Guardian

Print Name:

PLEASE NOTE: Where possible the need for medicines to be administered at the academy should be avoided. Parents are therefore requested to try and arrange the timings of doses accordingly.