Tickhill Estfeld Primary School

PARENTAL CONSENT FORM
ADMINISTRATION OF PRESCRITION-ONLY MEDICINES AT SCHOOL

NAME OF PUPIL _____

CLASS _____ AGE _____ DOB _____

CONDITION OR ILLNESS _____

_____

MEDICATION & DOSAGE (As described on the container)

_____

- medicine must be a prescribed medicine and in its original container as dispensed by the pharmacist. It must be clearly labelled with the child's name and instructions for administration.
- medicines will be administered as described on the label.
- please ensure that the medicine is delivered to and collected from the school office by an adult.

In signing this form I understand the medicine will be administered to my child by a member of school staff as described on the medicine label.

NAME _____ RELATIONSHIP TO PUPIL _____

DAYTIME TELEPHONE NUMBER _____

SIGNATURE _____ DATE _____

Date	Time	Person administering medicine	Signature	Witness	Signature