Temporary Administration of Medication in School Consent Form

Name of Pupil:

____

Class:

____

Teacher:

____

I request permission for my son/daughter to be given the following medication during school hours by the class teacher or a designated member of staff.

Medication:

____

Dosage:

____

When taken:

____

Doctor's name:

____

Doctor's telephone number:

____

I understand that whilst all best efforts will be made, staff of Walker Memorial Primary School accept no responsibility whatsoever for omitting to administer this medicine or administering the medicine at a time different from that specified above.

Signed (Parent/Guardian):

____

Date:

____

Please note that this form relates to temporary administration of medication. Any child requiring ongoing medication requires a personal medical care plan which will be discussed and agreed with the Principal and signed by both parties.