

Complete for prescribed or over-the-counter medication

If more than one medicine is to be given a separate form should be completed for each one.

Name of pupil	
Date of birth	Tutor group
Medical condition or illness:	
Symptoms	
Medication and strength	
Expiry date of medication	
Any precautions, or side effects experienced previously (IF NONE, PLEASE STATE "NONE")	

All medication must be in date, in its original packaging, and clearly labelled with name, administration directions and expiry date

Emergency Contact Details	
Name	Name
Relationship	Relationship
Contact number	Contact number
Doctor's name and surgery	
Any other relevant information:	

I would like my child to keep their medication on them for use as necessary. I confirm that my child has taken this medication previously without suffering any side effects.

I understand that the medication must be labelled clearly with my child's name and that it is my responsibility to ensure that the medication is in date. I confirm that my child is responsible enough to manage their own medication, including knowing the maximum dosage and frequency for their age, and that they understand that under no circumstances may their medication be shared with another pupil.

Parent/carer's signature:	
Print name:	
Date:	