APPENDIX ONE - **MEDICATION PERMISSION FORM**

In signing this form, parents give permission for the administration of prescribed medication as

detailed by a doctor for short-term illness and in an emergency for long-term illness.

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| Pupil’s name |  | Year |  |
| DETAILS OF MEDICINE PROVIDED |
| Date |  |
| Name of medication |  |
| Dose |  |
| This course of medication lasts for  |  |
| Reason for Medication or Medical Condition |  |
| Device/Equipment/Bottle Provided |  |
| Expiry Date of Medication |  |
| Signature of Parent |  |
| Signature of Staff Member/Headmistress |  |
| ADMINISTRATION OF MEDICATION |
| Time/Date medication was administered |  |
| Dose |  |
| Name of staff administering medication |  |
| Signature of staff administering medication |  |
| Signature of witness |  |
| Medication stored correctly | Yes/No (Delete as appropriate) |
| RETURN OF MEDICATION |
| Time/Date medication returned to parents |  |
| Signature of staff member |  | Signature of parent |  |

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| MEDICATION PERMISSION FORM |

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| RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL CHILD |
| Pupil’s name |  | Year |  |
| DAY 2 |
| Time of last dose | Dose to be administered | Time of next dose | Parent signature |
|  |  |  |  |
| Time medication was administered | Dose administered | Staff signature | Witness signature |
|  |  |  |  |
| Medication stored correctly Yes / No | Time medication returned |  |
| DAY 3 |
| Time of last dose | Dose to be administered | Time of next dose | Parent signature |
|  |  |  |  |
| Time medication was administered | Dose administered | Staff signature | Witness signature |
|  |  |  |  |
| Medication stored correctly Yes / No | Time medication returned |  |
| DAY 4 |
| Time of last dose | Dose to be administered | Time of next dose | Parent signature |
|  |  |  |  |
| Time medication was administered | Dose administered | Staff signature | Witness signature |
|  |  |  |  |
| Medication stored correctly Yes / No | Time medication returned |  |
| DAY 5 |
| Time of last dose | Dose to be administered | Time of next dose | Parent signature |
|  |  |  |  |
| Time medication was administered | Dose administered | Staff signature | Witness signature |
|  |  |  |  |
| Medication stored correctly Yes / No | Time medication returned |  |

*Please attach additional sheets if medication is required for more than 5 school days.*