BLACKFORDBY ST MARGARET'S
CofE PRIMARY SCHOOL

Blackfordby St. Margaret's CofE Primary School

Medicine Consent Form

Childs Details

Name			
Class			
D.O.B		Age	
My child has been diagnosed as having:			

Medication Details

Medication						
Dosage						
Required time/s of dosage	1st		2nd		3rd	
Start date						
End date						
Additional Information (take with food, keep refrigerated etc..)						

By signing this form, I confirm the following:

- They are considered fit for school but require the above medication.
- They have taken at least two doses of this medicine before returning to school.
- They have not had any adverse reaction to the medication.
- I will update school with any changes to medication routine or dosage.
- I understand that staff will be acting in the best interests of the child whilst administering the medication.
- I understand school will keep a record of medication given.

Parent / Guardian Name and Signature		

FOR SCHOOL USE:

Staff Name and Signature:		
Date:		