Chellaston Junior School
Medication Permission and Record

The school will not be able to give your child medicine unless you complete and sign this form.

Child's Name _____ Class _____

Details of illness _____

Name of medication _____

Dose and method _____

When it is to be taken (time of day)_____

First date of administering medication _____

Last date of administering medication _____

I understand that I must deliver the medicine personally to the school office and accept that this is a service which the school is not obliged to undertake. Medicines will be returned to your child at the end of the school day, unless otherwise agreed with you.

Signature _____ Date _____
(Parent/Carer)

Record of medication administered to pupil:

Date	Time Given	Dose Given	Member of Staff	Initials