CONSENT TO SELF ADMINISTER MEDICINES

The school staff will not allow pupils to self administer medicines unless this form is completed

I request and authorise that my child be allowed to take the following medication:

Name _____ **Date of Birth** _____

Address _____

_____

Phone No _____ **Class** _____

Name of Medication _____

Nature of Condition or Illness _____

Time and frequency of Dose _____

Dosage _____

Expiry Date of Medication _____

Side Effects School Need to Know About _____

Procedures to take in emergency _____

Name of GP who prescribed the medication _____

Telephone No of GP _____

Signed _____ **(Parent/Carer)** **Date** _____

Emergency Contact No _____