Highcliffe St Mark Primary school

Consent form for Administration of Medicine – Long term

Childs Name:		Class:	
Address:			
Contact Phone No:			
Reason for medication:			

Name of Medication	Dose	Frequency or time(s)
Expiry Date		

Medication should be administered from: -

Time: _____ Date: _____

Medication should not be administered after: -

Time: _____ Date: _____

Special Instructions (if any): _____

I agree to a member of staff administering medicines or providing treatment to my child as directed above or in the case of emergency, as staff consider necessary.

Signed (parent or carer) _____

Print name: _____

Date: _____

To be completed by a member of school staff:
I confirm that I have checked the details of the prescribed medication against the information on the label:

Signed: ……Date:……