Appendix 5

MEDICATION PERMISSION AND CONSENT FORM

Rossall
Broadway, Fleetwood,
Lancashire, FY7 8JW
Tel: 01253 774287
Email: medical@rossall.org.uk

PUPIL'S INFORMATION

Name of school:		Date medication provided by parent/guardian:	

Name of pupil:		Name of medication:	

Year and House:		Dose of method of administration:	

Any other information:	

Time and day to be given:		Expiry date:	

Medication must be in the correct container and packaging.

Pupil's name and dosage must be clearly written on package or bottle.

School Nurse signature:	*Parent's signature*

Print name:	*Print name and contact telephone number:*

Time given:	*Date given:*	*Signed by Nurse:*