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Child's Name: \_\_\_\_\_

Child's National Health Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of Medicine 1 : \_\_\_\_\_

Dose and Frequency of Medicine: \_\_\_\_\_

Start and/or Expiry of Prescription (DD/MM/YY): \_\_\_\_\_

Name of Medicine 2 : \_\_\_\_\_

Dose and Frequency of Medicine: \_\_\_\_\_

Start and/or Expiry of Prescription (DD/MM/YY): \_\_\_\_\_

Name of Medicine 3 : \_\_\_\_\_

Dose and Frequency of Medicine: \_\_\_\_\_

Start and/or Expiry of Prescription (DD/MM/YY): \_\_\_\_\_

Doctor's Name and Surgery Telephone Number:

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Other relevant medical information (i.e. Allergies, family medical history):

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Parent's/Carer's or Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Emergency Contact Numbers (Home and Mobile): \_\_\_\_\_

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I give my consent to the First Aider, or a delegated member of staff to administer the above medication according to the details given here and any other relevant medical advice which I have made clear to the Headteacher at Europa School.

Signature of Parent/Carer:

Date:

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If you have any questions or comments please get in touch with the office.

**Please Note: Members of staff at the School will not be able to administer medication to your child if you do not complete and return this form.**

School use: Please sign when the medication has been administered.

Name Pupil:

Class:

Dose and time:

Can Child administer own medicine? (Please circle) Yes / No

Date	Time	Signature