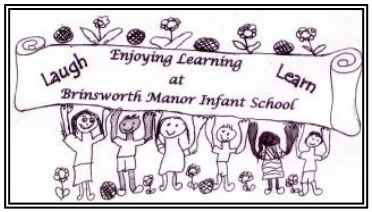

Permission from parents/carers to give medicine during school hours.

THIS FORM MUST BE FILLED IN CORRECTLY OTHERWISE MEDICINE WILL NOT BE GIVEN

Child's Name:_____ **Class:**_____

Name of medicine:_____ *(Parents please copy the name of the medicine from the box/bottle and write here)*

PARENTS to fill in this section-ALL columns must be filled in.						**AUTHORISED MEDICAL STAFF** to fill in this section	
Medicine needed for: *(Please state condition, e.g. tonsillitis, eye infection etc.)*	**Dosage** *(Please state number of spoonful's if medicine, number of drops if for eyes/ears etc.)*	**Special instructions** *(e.g. if eye /ear drops, state whether it is left or right eye/ear, if medicine state if it's with a syringe or spoon)*	**Date(s)** *(Please write everyday if needed every day. We can only give medicine on days recorded on this sheet)*	**Time(s) Needed.**	**Where should the medicine be stored?** *(e.g. cupboard/fridge)*	**Time given**	**Staff signature**

***Parents please read and sign the following*:**

- I give permission for my child to be given the medicine stated above
- I agree that if any changes to times or dosage requirements occur, it is my responsibility to inform staff of this and amend changes on this form.

Parent signature:_____ Parent name: *(Please print)* _____