



Aministration of Medication Permission Form

Name of school	
Child's name	
Year group	
Date of birth	
Child's address	
Medical diagnosis or condition	
Date	
Review date	
Family/Emergency Contact Information	
Name and Relationship to child	
Phone no. (work)	
(home)	
(mobile)	
Name and Relationship to child	
Phone no. (work)	
(home)	
(mobile)	
Name and Relationship to child	
Phone no. (work)	
(home)	
(mobile)	
Clinic/Hospital Contact	
Name	
Phone no.	
G.P.	
Name	
Phone no.	

Who is responsible for providing support in school

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the pupil's educational, social and emotional needs

Other information

Describe what constitutes an emergency, and the action to take if this occurs

Who is responsible in an emergency (*state if different for off-site activities*)

Staff training needed/undertaken – who, what, when

Signed:

Date: