



# St Mary's RC Primary School

## Administration of Medicine to Pupils – Parental Permission

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### Pupil information (Completed by Parent)

Date medication provided by parent:

Full name of pupil:

Date of birth:

Class/Year group:

Name of medication:

Condition/illness:

Dose and method (how much and when taken):

When is it taken (time of day):

Is your child able to self-administer? Y/N

Quantity received

Expiry date

Any other information

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### Medication Return (Completed by Staff Member)

Date and quantity of medication returned to parent:

Employee name:

Employee signature:

## Consent

I confirm that I will comply with the Schools *Administration of Medication Policy* and I give my consent for medication to be administered by a member of the school staff (or self-administered if applicable) in the circumstances described above.

Name:

Signed:

(Must be signed by a parent)

Date:

Record of Administration (To be completed by a staff member in school)

<b>Date and Time Given</b>	
<b>Dose Given</b>	
<b>Member of Staff (initialled)</b>	

<b>Date and Time Given</b>	
<b>Dose Given</b>	
<b>Member of Staff (initialled)</b>	

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<b>Dose Given</b>	
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