**MEDICATION PERMISSION FORM**

**Name: Class:**

* I give permission for a designated member of staff at Eastwood Community School to give medication to my child for a period of days / weeks.
* I understand that they will follow the instructions from the GP / Hospital via the instruction leaflet and label on the medication, as directed by me and give the medication at the prescribed times and as per the prescribed dosage.
* If my child refuses to take this medication, I understand that I will be called and asked to administer it myself.
* I consent to medical information being shared with other school staff and/or health professionals in the interests of his/her welfare.
* If an emergency situation occurs, please call the number below.

**Name of medication:**

**Signed: parent / guardian**

**Emergency contact number:**

**Date:**

**MEDICATION ADMINISTRATON LOG**

Each item of medication must be delivered in it’s original packaging and must be clearly labelled with the following information:

Pupil’s name, name of medication, frequency of dosage, date of dispensing, storage requirements (if necessary) and expiry date.

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| --- | --- | --- | --- | --- |
| **Date** | **Time** | **Name of medication** | **Dosage given** | **Signed** |
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