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| **Churchill Primary School**  **ADMINISTRATION OF MEDICATION PERMISSION FORM**  ***[TO BE COMPLETED BY PARENTS/CARERS]*** | | |
| Name of Pupil: |  | |
| Class: |  | |
| **I request permission for my child to be given the following medication during school hours by the class teacher or a designated member of staff.** | | |
| Medication |  | |
| Dosage |  | |
| Time to be taken |  | |
| Doctor’s name and telephone number: |  | |
| **I understand that whilst all best efforts will be made, staff of Churchill Primary School accept no responsibility whatsoever for omitting to administer this medicine or administering the medicine at a time different from that specified above.** | | |
| Parent/Carer Signature: |  | Date: |
| **Please note that this form relates to temporary administration of medication. Any child requiring on-going medication requires a personal medical care plan which will be discussed and agreed with the Principal and signed by both parties.** | | |