Appendix 1

Pupil Name:

Address:

Date of Birth:

The Avenue School
Special Needs Academy

Medication consent and full direction for use

1. Name/Type of medication: ……
   Dosage: ……
   Time to be given: ……
   This medicine is given because: ……
   Is this the first time the pupil has taken this medication? Yes or No

2. Name/Type of medication: ……
   Dosage: ……
   Time to be given: ……
   This medicine is given because: ……
   Is this the first time the pupil has taken this medication? Yes or No

3. Name/Type of medication: ……
   Dosage: ……
   Time to be given: ……
   This medicine is given because: ……
   Is this the first time the pupil has taken this medication? Yes or No

Allergies

List any known allergies for school to be aware and if any are diagnosed.

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……

Contact Details: Parent/Guardian

Name: ……
Daytime telephone number: ……
Address: ……
Relationship to pupil: ……

I request that a member of staff administer the above medication/s. I will inform the school and school nurse immediately of any medication changes. Medication must be in the original bottle or packages as dispensed by the pharmacist.

Signature: …… Date: ……
Print name: ……