AUTHORISATION OF ADMINISTRATION OF MEDICINE TO A PUPIL

Name of Child: _____

Year: _____

Name of Medicine: _____

Dosage to be administered: _____

Time medicine to be administered: _____

Reason for needing medication: _____

Parent/Guardian's Signature: _____

Parent/Guardian's mobile contact number (Day Time) _____

Date: _____

Date	Time medicine given	Dosage given	Member of Staff