**HARLINGTON LOWER SCHOOL**

**PERMISSION TO ADMINISTER MEDICATION**

CHILD'S NAME……

CLASS……

NAME OF
MEDICINE……

HOW MUCH TO GIVE PER DOSE……

MEDICAL CONDITON OR
ILLNESS……..……

WHEN TO BE GIVEN……

ANY OTHER INSTRUCTIONS, INCLUDING POSSIBLE SIDE EFFECTS
……..

CONTACT PHONE NO…….

MEDICINE TO BE LEFT AT SCHOOL ☐

MEDICINE TO BE TAKEN HOME
EACH DAY ☐

In consideration for the Head Teacher or the School's staff agreeing to give medicine to my above named child during school hours. I/we agree to indemnify the Head Teacher, the School's staff and the Local Education Authority against all claims, costs, actions and demands, whatsoever resulting from the administration of the medicine unless such claims, costs, actions or demands result out of negligence of the Head Teacher, the School's staff or the Local Education Authority.

Parent's signature…….

If more than one medicine is to be given a separate form should be completed for each.

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DATE | | | | | | | | | | | | | |
| TIME GIVEN | | | | | | | | | | | | | |
| SIGN | | | | | | | | | | | | | |

Date medicine returned to parent……