SOUTH WILTS GRAMMAR SCHOOL

Parent / Carer Consent for the Storage / Administration of Medication

If you would like the School to store your child's medication, please complete this form and return to Reception with the medication, in a clearly named bag

Details of pupil

Surname _____ Forename(s) _____ Form _____

Condition or illness _____

Name / type of medication (as described on container) _____

For how long will your daughter take this medication? _____ Date dispensed _____

Full directions for use if the student is self-administering

Dosage _____ Timing _____

✓

Please indicate whether this medication is compulsory, as part of a course of treatment or for self-administration as and when required?

As part of course of Treatment: ☐ **OR** As and when required: ☐ Does the medication need to be refrigerated? ☐

Other Relevant Information _____

Procedures to take in an emergency

_____

_____

_____

I understand that the medication must be delivered to Reception by hand and accept that this is a service which the school is not obliged to undertake.

Date _____ Signature _____ Relationship to pupil _____