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**Eversfield Medication Consent Form**

**Pupil Details**

Full Name:       Form:

Date of Birth:

**Medication Details**

Name of medication:

Reason for medication:

Duration required for medication:

**PLEASE NOTE THAT WE WILL ONLY ADMINISTER over the counter PARACETOMOL/ IBUPROFEN FOR A MAXIMUM OF 2 DAYS UNLESS PROVIDED WITH A DOCTOR’S NOTE.**

**Directions for use/dosage instructions**

Dosage:       Timings:

Self-administration: Yes/No

Special precautions if any:

Time last dose given at home (if applicable):

**Contact details**

Name:       Relationship to child:

Contact telephone numbers:

**I understand that medications must be delivered by a responsible person to an adult within the school. I understand that all medications will be stored safely and securely in school.**

Signed:       Date: