TORBAY COUNCIL CHILDREN'S SERVICES CS 1S 94

ADMINISTRATION OF MEDICINES IN SCHOOLS

Name of School .....

Name of Pupil .....

Address .....

.....

Medical condition of pupil .....

Name of prescribing doctor .....

Medicine .....

Dose ..... Frequency of dose .....

1. I confirm that the above medicine has been prescribed by a doctor, and that I give my permission for the Head Teacher (or his/her nominee) to administer the medicine to my son/daughter during the time he/she is at school.

   Signed .....
   (Parent/Guardian/Person with parental responsibility)

   Date .....

2. I give my permission for my son/daughter to carry their asthma inhaler with them whilst at school and to manage its use.

   Signed .....
   (Parent/Guardian/Person with parental responsibility)

   Date .....

3. I give my permission for my teenage son/daughter to manage the use of his/her pen injector for diabetes.

   Signed .....
   (Parent/Guardian/Person with parental responsibility)

   Date .....

(See notes for guidance overleaf)