APPENDIX 1

WROCKWARDINE WOOD C.E. JUNIOR SCHOOL

MEDICATION PLAN

Please complete this form and return it to school with the medication. No medication will be administered without signed parental permission.

**DETAILS OF PUPIL**

Surname: ……………………………………………………………………………..

Forename(s): …………………………………….. M/F: …………………………..

Date of Birth: ……………………………………..

Class: …………………………

**MEDICATION**

Name/Type of Medication

(as described on the container) …………………………………………………….

For how long will your child take this medication: ………………………………...

Date dispensed: ………………………………………………………………………

**DIRECTIONS FOR USE**:

Dosage and method: …………………………………………………………………

Timing: …………………………………………………………………………………

(Please note: specific timing cannot be guaranteed)

Special Precautions: …………………………………………………………………

Side Effects: …………………………………………………………………………..

Self Administration: YES/NO

Procedures to take in Emergency: …………………………………………………

Details of Medication taken at home: ………………………………………………

**CONFIRM CONTACT DETAILS**

Name: ………………………………………………………………………………….

Daytime Telephone No ………………………………………………………………

Relationship to Pupil …………………………………………………………………

Address: ……………………………………………………………………………….

I understand that I must deliver the medicine personally to the school office and accept that this is a service which the school is not obliged to undertake.

Date: ………………….. Signature………………………………………………….

Relationship to pupil: ………………………………………………………………..