|  |  |
| --- | --- |
| Name of school | Ferndown Middle School |
| Name of child |       |
| Date medicine provided by parent |       |       |       |  |
| Tutor Group |       |
| Address |       |
| Quantity received per item |       |
| Name and strength of medicine |       |
| Expiry date |       |       |       |  |
| Dose and frequency of medicine |       |

|  |
| --- |
| Procedures to be taken in an emergency.      |

**Contact Information**

|  |  |
| --- | --- |
| Parent name |       |
| Daytime contact no(s) |       |
| Relationship to child |       |

I would like my son/ daughter to keep his/ her medicine on him/ her for use as necessary.

Signature of parent       Date      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

*If you have any questions or concerns please contact the school office and ask to speak to a designated first aider.*