|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of school | Ferndown Middle School | | | |
| Name of child |  | | | |
| Date medicine provided by parent |  |  |  |  |
| Tutor Group |  | | | |
| Address |  | | | |
| Quantity received |  | | | |
| 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.

My child will not carry medication on their person.

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.*