Bolingbroke Academy

Medication Form

Date: ______________

Pupil Name:_____________________________ Pupil Surname: ________________________________

Medication: _____________________________ Required for: _________________________________

To be taken from: _______To: ________Prescribed on: __________ Expiry date: _______________

Dosage:

Frequency	Quantity	Morning	Lunch	Afternoon
Daily				
Weekly				

Is this a recurring issue? E.g.: allergies, cramps, etc. **YES** ☐ **NO** ☐

If **YES**, do you give permission for your child to decide when medication is needed? **YES** ☐ **NO** ☐

Any other notes: ____

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When course is finished/expired remaining medication should be: Returned to parent ☐

Disposed of by school ☐

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

___________________________________ ___________________________________

Parent/Carer Signature Parent/Carer Print Name