The information below is, to the best of my knowledge, accurate at the time of writing and I give consent for a member of staff at Castlecombe Primary School to administer the prescribed medicine in accordance with the school policy. I will inform the school immediately, in writing if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Name of Child		
Date of medicine provided by parent		
Class		
Medical Condition or Illness		
Expiry Date		
Quantity Returned		
Name of Medicine	Dosage	Prescribed by (name of doctor)
Time(s) to be given	Date(s)	

Signature of parent/guardian……..

Record of medicine given

Date	**Time**	**Dose**	**Signed**	**Date**	**Time**	**Dose**	**Signed**