Medical Permission Form

WALKERINGHAM PRIMARY SCHOOL

Child's Full Name:	
Date of Birth:	
Medical Condition / Illness:	
Child's Address:	
GP Name:	
GP Phone No.	

List of Prescribed/Non Prescribed Medicines

Name of Medication and Strength	Dosage	Frequency	Expiry Date	Duration	Date to Commence

Additional Instructions:
Special Precautions/Side Effects/Procedures to take in an emergency

I understand that I must deliver the medicine to the school office. I accept that this is a service that the school is not obliged to undertake. I understand that I must notify the school of any changes in writing. I confirm that my child is not allergic to the above medication.

GP Letter Received	Yes / No
Parent Name	
Parent Signature	
Date:	

Date	Dosage Given	Time Given	Staff Signature	Reaction to Medication (Y/N)

*Please note this form must be accompanied with the Medical Permission Form