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| Date for review to be initiated by: | |
| Name of Academy/setting: | Belgrave St Peter's C of E Primary School |
| Name of child: | |
| Date of birth: | |
| Group/class/form: | |
| Medical condition or illness: | |

MEDICINE

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| Name/type of medicine (<i>as described on the container</i>): NB: Medicines must be in the original container as dispensed by the pharmacy | |
| Expiry date: | |
| Dosage and method: | |
| Timing: | |
| Special precautions/other instructions: | |
| Any side effects that the Academy/setting needs to know about: | |
| Self-administration – Y/N: | |
| Procedures to take in an emergency: | |

PARENT/CARER CONTACT DETAILS

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|-----------------------|--|
| Name | |
| Daytime telephone no. | |
| Relationship to child | |
| Address | |

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| I understand that I must deliver the medicine personally to [agreed member of staff] | |
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The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Belgrave St Peter's C of E Primary School staff administering medicine in accordance with the Academy policy. I will inform the Academy immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

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| Parent/carer signature: | |
| Parent/carer name: | |
| Date: | |