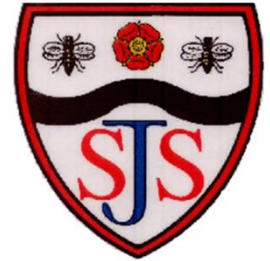


# Shadsworth Junior School



## Consent for School to Administer Medication

Name of Child: \_\_\_\_\_

Class: \_\_\_\_\_

Medical Condition or Needs	
Name of Medication	
Dosage	
Timing	
Any other information	

### Medicine Administration

Tick as Appropriate:

My child can take their own medicines (self-administration)		My child needs assistance to take their medicine (supported administration)	
--	--	--	--

Name of person completing form	
Relationship to child	

### **By signing this form, I confirm:**

- That I am aware the school may only administer medicines that are within their expiry dates.
- That my contact details held by the school are up-to-date.
- That the school is not obliged to provide this service and may decline to do so at any time.
- That I will notify the school of any changes regarding medications immediately.

Signature	
Date	