Pupil Medication Consent

Kimbolton School

General Information

Pupil's Name:	
Date of Birth:	
Form:	
Parent/Guardian Name:	
Emergency Contact Number(s):	

Medical Information

Name of Medication:	
Reason for Medication:	
Time of Administration:	
Dosage and Administration Method:	
Period of Medication (Dates):	
Allergies/Special Consideration:	

Parent Declaration

I hereby request that the School administers this medication, according to these instructions and only for the period stated. I understand that the **medication must be provided in a pharmacy-labelled container** with my child's name, date of birth and full prescription details (in case of prescription medicine) on it. I also acknowledge that it is my child's responsibility to present him/herself to the Medical Room at the right time so that the medication can be administered. I understand that all medication must be delivered direct to the Medical Room immediately upon arrival at School

Signed by Parent/Guardian:	
Print:	
Date:	