Fair Hill Primary School

Consent Form for Administration of Medicines

Name of Pupil:_____

Class:_____

Teacher:_____

I give permission for my son/daughter to be given the necessary medication by the class teacher or a designated member of staff during school hours.

Medication:_____

Dosage:_____

When taken:_____

Signed:_____

Relationship to the above named pupil:_____

Date:_____

PLEASE COMPLETE AND RETURN TO THE SCHOOL