

## Appendix 6: Medicines permission letter for pupils with medical conditions

In line with this school's 'Supporting Pupils at School with Medical Conditions' Policy, the school will not give your child medicine unless you complete and sign this form.

Name of school/setting	
Date	
Pupil's name	
Group/class/form	
Name and strength of medicine	
Reason for use	
Expiry date	
How much to give (i.e. dose to be given)?	
When to be given	
Any other instructions	
Number of tablets/quantity to be given to school/setting	

**Note: Medicines must be in the original container as dispensed by the pharmacy**

Daytime phone no. of parent/carer	
Name of GP, GP practice name and phone number	
Agreed review date to be initiated by	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school's policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medicine or if the medicine is stopped.

Parent/carers signature .....

Print name .....

Date .....

Designated member of staff's signature .....

Print name .....

Date .....