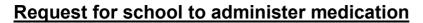
## St Peter's CEP School



**DETAILS OF PUPIL** 



The school will not give your child medicine unless you complete and sign this form, and the Headteacher has agreed that school staff can administer the medication.

Surname:			Class:
Forename(s): .			
M/F	Date of Birth:		
	ess:		
MEDICATION			
Name/Type of N	Medication (as described on the	container)	
For how long w	ill your child take this medication	?:	
Date dispensed	l:	Expiry date:	
Full Directions Dosage and me	s for use: ethod:		
Date and Time:			
Special Precaut	tions:		
-	ide effects that the school needs		
	tion: Yes / No ( <i>delete as approp</i>		
Procedures to t	ake in an emergency:		
	must be in the original contair	ier as dispensed	by the pharmacy.
CONTACT DE	ΓAILS:	Daytime Te	el No:
		-	
Relationship to	Pupil:		
I understand that	at I must deliver the medicine pe	rsonally to a mem	ber of staff.
Signature:		Date	