Castlecombe Primary School
Castlecombe Road
Mottingham
London
SE9 4AT

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Medicine Permission Form

I give permission for a member of staff at Castlecombe Primary School to administer the prescribed medicine as detailed below:

Name of child:.....
(Receiving medication)

Year Group:.....

Name of Medicine:.....

Dosage: .....

Prescribed by (name of doctor):.....

Time(s) to be given:.....

Date(s): .....

Signature of parent/guardian: .....

Record of medicine given							
Date	Time	Dose	Signed	Date	Time	Dose	Signed