



**MEDICATION AUTHORISATION / REQUEST TO ADMINISTER MEDICATION
FOR SPECIAL SCHOOLS WITH A NURSE ON SITE**

The school nursing staff or school staff will not give your child any medication unless you complete and sign the form.

CHILD / YOUNG PERSON'S DETAILS:

NAME.....

ADDRESS.....

..... TEL.....

DATE OF BIRTH...../...../..... NHS NUMBER..... **MALE / FEMALE**
(please circle)

ALLERGIES.....

PAGE..... OF.....

Medication & strength	Time	Dose	Full directions for use

I understand that I must inform the transport escort that medicines are being transported to school.

I consent to the school nursing staff or school staff giving the above medication to my child.

Name

Date

Signature

Relationship to pupil