Whittington Health NHS

The Brook Special Primary
Adams Road
Tottenham
N17 6HW
020 8808 7120

THE SCHOOL WILL NOT GIVE YOUR CHILD MEDICINE UNLESS YOU COMPLETE AND SIGN THIS FORM, AND WHERE APPROPRIATE FORM AOM 1A WHICH SHOULD BE COMPLETED BY THE GP

Details of Pupil

SURNAME..... FORENAMES:.....
Address..... M/F.....
..... Date of Birth.....
..... Class/Form.....

Condition or illness: _____

Name/Type of Medication (as described on container) _____

For how long will your child take this medication _____

Date Dispensed _____

FULL DIRECTIONS FOR USE

Dosage: _____

Timing: _____

Special Precautions _____

Side Effects: _____

Self Administrations: _____

Procedures to take in an Emergency _____

_____

Contact Details:

Name..... Daytime Tel No.....

Relationhip to Pupil.....

Address.....
.....

I understand that I must deliver the medicine personally to an agreed member of staff and accept that this is a service which the school is not obliged to undertake.

Date:..... Signed.....

Relationship to pupil.....