MOUNT HAWKE ACADEMY

MEDICINE FORM



**CONTACT DETAILS/AUTHORISATION:**

NAME:..............................................................PARENT/GUARDIAN/OTHER\*

IF OTHER PLEASE STATE.............................................................................

DAY TIME CONTACT TELEPHONE NO:...........................................................

**I UNDERSTAND THAT I MUST DELIVER/COLLECT THE MEDICINE PERSONALLY TO THE OFFICE STAFF & FROM THE CLASS TEACHER. I ACCEPT THAT THIS IS A SERVICE WHICH THE SCHOOL IS WILLING TO BUT NOT OBLIGED TO UNDERTAKE.**

SIGNATURE................................................................DATE.........................

**MEDICATION:**

NAME OF MEDICATION:………………………………………………………………………….

DOSAGE: 5ML / 10ML \* SPOON/SYRINGE \* TABLET\*

(PLEASE DELETE APPROPRIATELY)

TIMINGS:…………………………………………………………………………………………………

ADDITIONAL REQUIREMENTS:.....................................................................

ADMINISTRATION

|  |  |  |  |
| --- | --- | --- | --- |
| DATE | TIME | DOSAGE | SIGNATURE |
|  |  |  |  |
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|  |  |  |  |

**PUPIL DETAILS:**

FIRST NAME:………………………………SURNAME:…………………………………………..

D.O.B:………………………………………CLASS:………………………………………………….

MEDICAL CONDITION:……………………………………………………………………………..

………………………………………………………. INFECTIOUS? YES / NO (PLEASE DELETE)