MOUNT HAWKE ACADEMY
MEDICINE FORM

PUPIL DETAILS:

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

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

MEDICAL CONDITION:.....

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

MEDICATION:

NAME OF MEDICATION:.....

DOSAGE: 5ML / 10ML * SPOON/SYRINGE * TABLET*
(PLEASE DELETE APPROPRIATELY)

TIMINGS:.....

ADDITIONAL REQUIREMENTS:.....

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.....

ADMINISTRATION

DATE	TIME	DOSAGE	SIGNATURE