MADRAS V.A.PRIMARY SCHOOL, PENLEY, WREXHAM

Authorisation to administer essential medication in school.

Name of Child ……..

Medication name and dosage**, including times to be administered**;-

……

……

Number of days to be administered ……

Reason for medication:-

……

……

Signature…… (Parent / Guardian)

Date ……..

For school use

Date	**Time administered**	**Signature**