Cilffriw Primary
Administration Of Medication Form

I request that staff at Cilffriw Primary School administer the following medicine to my child:

Name of child:	**Class:**
Name of Medicine:	**Amount to be given (dosage):**
When should the medicine be given?	**Any further information:**
Name of prescribing doctor:	**Date of prescription:**

I give my consent for the school to administer medicine as detailed above.
I understand that the staff are not responsible for any reactions or complications resulting from the administration of medication according to the directions.

Signed:_____ (Parent/Guardian) Date:_____