

**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/FROM THE OFFICE STAFF & 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: (REASONABLE ENDEAVOURS) BETWEEN 12 – 1PM

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

ADMINISTRATION

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

MOUNT HAWKE ACADEMY

MEDICAL FORM

**PUPIL DETAILS:**

FORENAME:………………………………SURNAME:……………………………………………..

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

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

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