

# Chipstead Valley Primary School

## SHORT TERM MEDICATION FORM

Please complete this form if your child requires short term medicine to be held in school.

All medication must be clearly labelled with your child's name and class. Please note that **you** have the responsibility to ensure that your child's medicine is kept in date. All medication should be collected on the last day of term.

Child's Name: \_\_\_\_\_ Class: \_\_\_\_\_

Condition: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Expiry: \_\_\_\_\_

Prescribed:  Doctor's Letter:

Known side-effects: \_\_\_\_\_

Does the medication need to be refrigerated? Yes/No

Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Date from: \_\_\_\_\_ Until: \_\_\_\_\_

Any other specific instructions: \_\_\_\_\_

A contact number for the day if needed: \_\_\_\_\_

Email address: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Carer's signature: \_\_\_\_\_ Print name: \_\_\_\_\_

Please give details of any after school clubs your child is attending during this period: \_\_\_\_\_

\_\_\_\_\_

**Office Use:** Note to Class Teacher

### TAKEN HOME BY:

Parent/Carer name	Signature	In presence of	Date