

Falmouth School will not give your child medication unless you complete and sign this form.

Date for review to be initiated by	
Name of school/setting	Falmouth School
Name of student	
Date of birth	
Tutor group	
Medical condition/illness	

**Medicine**

Name of medicine as described on container	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Possible side effects	
Self administration y/n	
Procedures to take in an emergency	

**NB: Medicines must be in the original container as dispensed by the pharmacy**

**Contact details**

Name	
Telephone number	
Relationship to student	
Address	

- I understand that I must deliver the medicine personally to Falmouth School Reception.
- Emergency Medical Consent - This confirms your agreement for the school to initiate appropriate medical, surgical or first aid treatment deemed necessary by a qualified practitioner, if an emergency should occur at any time when your consent to treatment cannot otherwise be obtained.
- The above information is, to the best of my knowledge, accurate at the time of writing, and I give consent to Falmouth School administering medicine in accordance with Falmouth School's

Falmouth School will not give your child medication unless you complete and sign this form. I will inform Falmouth School immediately, in writing, if there is any change in dosage or frequency or if the medication is stopped.

Signature/s: \_\_\_\_\_

Date: \_\_\_\_\_