

FIVEWAYS SCHOOL ADMINISTRATION OF MEDICATION & FIRST AID

CHILD'S NAME:	
MEDICATION:	
Dosage	
Time to be Administered	
MEDICATION:	
Dosage	
Time to be Administered	
MEDICATION:	
Dosage	
Time to be Administered	
PERMISSION TO USE PLASTERS	YES/NO
ADMINISTRATION OF PARACETAMOL	YES/NO
Special Instructions or Allergies (emergency treatment)	
* I give my permission for Fiveways School Staff to assist my child with his/her personal hygiene needs as and when required. YES/NO	
I am aware that the school advises that my child's tetanus vaccination should be maintained.	

Parent/Guardian Signature: _____ Date: _____

ONCE COMPLETED PLEASE TEAR OUT & PLACE THIS FORM NEXT TO THE MOST RECENT CORRESPONDENCE IN THIS BOOK.