

Child's Name.....

Class ..YEAR 6 (2018)

This form **MUST** be returned to school **on the day of departure even if your child is not on any prescribed medication.**

Known allergic reactions (Medications)	Yes/No

Please complete Part A with details of medications **prescribed by the GP.**

Part A	Condition	Medication	Dose/ instructions
1.			
2.			
3.			
4.			

Please complete Part B with details of any **'over the counter'** medication (e.g. travel pills, painkillers, creams, etc.)

Part B	Condition	Medication	Dose/ instructions
1.	Headache etc	Calpol	As per manufacturer's recommended dosage
2.			
3.			
4.			

I request that the medications listed above be administered to my child as per my instructions and have provided it in the original packaging within a named container / food bag.

Signed Print Name.....

To be completed by member of staff responsible for medications on trip

Part C	Medication	Given by	Checked by	Date and Time