TROON CP SCHOOL

Administration of Medicine

Child's Name_____

Class_____

Date_____

Please administer_____ to my child

Dosage
required_____

Please note only prescription medicines can be administered (this does not include over the counter medicines)

Medicines will be stored in the office or in a refrigerator if required.

Inhalers will be stored in class rooms

I give permission for Troon CP School to give my child the medicine listed above.

Signed_____Parents/Guardian