EVERSLEY PRIMARY MEDICAL FORM

CHILD'S NAME_____CLASS_____

Contact Name_____ Telephone no: _____

Illness: _____

Medicine prescribed: _____

Dosage: _____

Time to be given in school: _____

Time medication was last given/any special instructions: _____

Any known allergy: _____

I authorise the qualified first aider to administer the above medicine and release them from all further liability or responsibility for any consequent adverse effects, reactions or any unforeseen circumstances which might arise.

SIGNED: _____ DATE: _____
Parent/Carer

MON:	TUES:	WED:	THUR:	FRI: