

PERMISSION FOR ACROSS THE COUNTER MEDICATION
(OLDER PUPILS ONLY)

Name of Pupil: _____

Date of Birth: _____

Class: _____

I agree to my son/daughter being allowed to carry the medication detailed below.

I understand that it is my responsibility to ensure he/she is aware of the safe and responsible use of this medication.

Name of medication:

Instructions for use:

Signature of Parent: _____
Date: _____