Bridge & Patrixbourne CEP School

If you wish a member of the office staff to administer your child's medicine, please complete the following form.

Child's Name ……

D.O.B. …… Class ……

Full name of medication ……

……

Dosage and time to be administered ……

Signed …… Date ……

FOR OFFICE USE ONLY

Date	Time	Medication	Administered by	Signed