



For Office Use Only
Student Photo and Tutor Group

'OVER THE COUNTER' MEDICINE FORM 2023-24

Student Name: _____ Form: _____ DOB: _____
Address: _____
Name of person who brought medicine in: _____
Signature _____ Relationship to Student: _____

Name of Medication - 1 (please include original packaging): _____
Reason for Medication: _____
Dosage: _____ Time: _____
(Please state quantity)
Expiry Date of Medication: _____
Does the medication need to be refrigerated: Yes / No

Name of Medication - 2 (please include original packaging): _____
Reason for Medication: _____
Dosage: _____ Time: _____
(Please state quantity)
Expiry Date of Medication: _____
Does the medication need to be refrigerated: Yes / No

Any unused medication at the end of the academic year to be:
 collected by parent disposed of by the school returned to student
Any out of date medication will automatically be disposed of by the school.

I authorise Cox Green School to administer the medication above.
Parent/Carer Signature: _____ Date: _____
Parent/Carer telephone number: _____

