Request for school to administer medication

The school will not give your child medicine unless you complete and sign this form, and the Headteacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Surname: _____ Forename(s) _____

Address: _____ M/F: _____

_____ Date of Birth: _____

_____House:_____Tutor Group/class: _____Year:

Condition or illness: _____

MEDICATION

Name/Type of Medication (as described on the container) _____

For how long will your child take this medication: _____

Date dispensed: _____Expiry Date:_____

Full Directions for use:

Dosage and method: _____

Timing: _____Does it need to be stored in the fridge?_____ _____

When did they take the medication last? _____

Special Precautions: _____

Side Effects: _____

Self Administration: _____

Procedures to take in an Emergency: _____

CONTACT DETAILS:

Name: _____ Daytime Tel No _____

Relationship to Pupil: _____ Address: _____

_____

I understand that I must deliver the medicine personally to Mrs Rowntree, Welfare Assistant and accept that this is a service which the school is not obliged to undertake.

Signature(s): _____ Date: _____

Relationship to pupil: _____

Only prescribed medicine in its original box and only the correct amount needed for the time they need their medication in school.