



REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION

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

Details of Pupil

Surname Forename(s).....

Address
.....

Date of Birth/...../..... Class M F

Condition or illness

.....
.....

Medication

Parents must ensure that in date properly labelled medication is supplied.

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

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Date dispensed Expiry Date

Full Directions for use :

Dosage and method

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.....

NB Dosage can only be changed on a Doctor's instructions.

Timing

Special precautions

Are there any side effects that the School needs to know about ?

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Procedures to take in an Emergency.

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Contact Details

Name

Phone number

Relationship to Pupil

Signed