



Parental request for at Dalton St Michael's CE Primary School to administer medicine

Name of child: _____

Date of birth: _____ Year group: _____

Details of illness: _____

Details of medicine: (please provide name of medicine as labelled on bottle/box)

Medicine 1 _____ Expiry date: _____

Medicine 2 _____ Expiry date: _____

Is this medicine Prescribed

 Over the counter

 Other (please give details) _____

About the medicine

Type	Dose	Time	Self-administration
Drops <input type="checkbox"/>	_____	_____	Yes / No
Inhaler <input type="checkbox"/>	_____	_____	Yes / No
Oral <input type="checkbox"/>	_____	_____	Yes / No
Other <input type="checkbox"/>	_____	_____	Yes / No

How many days to you anticipate your child will need this medication? _____

Does your child suffer from side effects when taking this medication? (If so please give details).

Procedures to take in an Emergency: _____

Contact Details

Name of parent / guardian _____

Daytime telephone number: _____

Relationship to child: _____

To the best of my knowledge, the above information is accurate. I give consent for staff at Dalton St Michael's CE Primary School to administer medicine in line with their own policies and procedures and this document.

I will inform the setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I understand I must deliver the medicine personally to the school office or class teacher in a named bottle/box and accept this is a service the setting is not obliged to undertake.

Signature: _____

Date: _____

For office use only:

Date	Medication	Dosage	Self-administered	Time	Initials
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		