

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

(Prescribed medicines only)

The school will not give your child medicine unless you complete and sign this form. Non prescribed medicines cannot be administered by the school.

DETAILS OF PUPIL

Surname Forename

Address

.....

Date of birth Class

Condition or illness:

.....

.....

MEDICATION

Name/Type of medication (as described on the container):

.....

How long will your child take this medication:

Date Dispensed:

Full Directions for Use:

Dosage and method:

Timing:

Special precautions:

Side effects:

Self administration:

Procedures to take in an emergency:

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

Name: Daytime telephone no:

Relationship to pupil: