

**Bugle School
Administration of Medicine**

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.

PUPIL DETAILS

Full Name : _____

Address: _____

Date of Birth: _____ Year Group: _____

Condition or Illness: _____

MEDICATION

Name of Medication: _____

Period of Medication: _____

Date Dispensed: _____

FULL DIRECTIONS FOR USE

Dosage and Method: _____

Time(s) : _____

Any Precautions: _____

Possible Side Effects: _____

Where does the medicine need to be kept: _____

I wish the medicine to be administered by: _____

CONTACT

IN THE EVENT OF AN EMERGENCY OR ANY DISCREPANCY WITH ADMINISTERING THIS MEDICATION THE SCHOOL SHOULD CONTACT

Name: _____ Relationship to Child: _____

Contact Number (1): _____ Contact Number (2): _____

STATEMENT

I UNDERSTAND THAT I MUST DELIVER THE MEDICATION PERSONALLY TO THE SCHOOL OFFICE (OR ANOTHER AGREED LOCATION) AND I ACCEPT THAT ADMINISTERING MEDICATION TO MY CHILD IS A SERVICE THAT THE SCHOOL IS NOT OBLIGED TO UNDERTAKE.

Signed: _____ Name : _____

Date: _____