

Request for school to administer medication

This form is for parents to complete if they wish the school to administer 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.

DETAILS OF PUPIL

Surname: _____ Forename: _____

Address: _____

M/F: _____ Date of Birth: _____ Year/Class: _____

Condition or illness: _____

MEDICATION (Office to check details below match medication/label etc)

Name /type of medication (as described on the container) _____

For how long will your child need to take this medication: _____

Date dispensed: _____

Full Directions for Use:-

Dosage and Method: _____

Timing: _____

Special Precautions: _____

Possible Side Effects: _____

Child able to Self-Administer: _____ Yes/No _____

Procedures to take in an emergency: _____

CONTACT DETAILS

Name: _____ Daytime Telephone Number: _____

Relationship to pupil: _____

If medicine is being brought in daily, I understand that I must deliver the medicine personally to (agreed member of staff) and accept that this is a service which the school is not obliged to undertake.

SIGNATURE: _____ **DATE:** _____ **RELATIONSHIP(S) TO PUPIL:** _____

OFFICE

Medication verified (Initial) - ☐ Fridge - Yes / No

HEADTEACHER AUTHORISATION

I consent to the above named pupil receiving medication as specified on this form and will be supervised whilst he/she is given/takes the medication.

Signed: (Headteacher) _____ Dated: _____