

NAME OF SCHOOL _____

REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION

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

Details of Pupil

Surname _____ Forename(s) _____

Address _____

Date of Birth ____/____/____

M F

Class _____

Condition or illness _____

Medication

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

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

Date dispensed _____

Expiry Date _____

Full Directions for use:

Dosage and method

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?

Self-Administration Yes/No (delete as appropriate)

Procedures to take in an Emergency

Contact Details

Name _____

Phone No: (home/mobile) _____

(work) _____

Relationship to Pupil _____

Address _____

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. I understand that I must notify the school of any changes in
writing.

Signature(s) _____ **Date** _____

Agreement of Principal

I agree that _____ (name of child) will receive
_____ (quantity and name of medicine) every day at
_____ (time(s) medicine to be administered eg lunchtime or
afternoon break).

This child will be given/supervised whilst he/she takes their medication by
_____ (name of staff member)

This arrangement will continue until _____ (either end
date of course of medicine or until instructed by parents)

Signed _____ **Date** _____

(The Principal/authorised member of staff)

**The original should be retained on the school file and a copy sent to the
parents to confirm the school's agreement to administer medication to the
named pupil.**