

# REQUEST FOR SCHOOL TO ADMINISTER MEDICATION



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 :

Surmane - ..... Forename (s) - .....

Address - .....

Date of Birth - ..... Class - .....

Condition or Illness - .....

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

For how long will your Child take this medication? - .....

Date Dispensed - .....

## FULL DIRECTIONS FOR USE :

Dosage - .....

Timing - .....

Special Precautions - .....

Side Effects - .....

Procedures to take in an Emergency - .....

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## CONTACT DETAILS :

Name - .....

Relationship to Pupil - .....

Daytime Telephone No. - .....

Address - .....

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I understand that I must deliver the medicine personally to (agreed member of staff / Class Teacher) and accept that this is a service which the school is not obliged to undertake.

Signed - ..... Date - .....