REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

We will not give your child medicine unless you complete and sign this form.

PUPIL DETAILS

SURNAME		**ADDRESS**	
FIRST NAME			
GENDER			
D.O.B.			
CLASS			
Condition or illness			

MEDICATION

Name/Type of Medication (As described on the container)	
For how long is it to be taken	
Date medication dispensed	

FULL DIRECTIONS FOR USE

Dosage and method	
Timing	
Special precautions	
Side effects	
Self-administration	
Emergency procedures	

CONTACT DETAILS

NAME		**DAYTIME NUMBER**	
RELATIONSHIP TO PUPIL		**MOBILE NUMBER**	
ADDRESS			

DECLARATION

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

Signature		**PRINT name**	
		Relationship to pupil	

Record of medicine administered to an individual child

Date	
Time given	
Dose given	
Name of member of staff	
Staff initials	

Date	
Time given	
Dose given	
Name of member of staff	
Staff initials	

Date	
Time given	
Dose given	
Name of member of staff	
Staff initials	

Date	
Time given	
Dose given	
Name of member of staff	
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