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.

PUPIL DETAILS Name: Address:	Date of Birth: Class: Male/Female (delete as applicable)

CONDITION OR ILLNESS

MEDICATION
Name/type of medication (as described on container) For how long will your child take this medicine Date dispensed

FULL DIRECTIONS FOR USE	
Dosage and method **Timing** **Special precautions**	**Side effects** **Self administration** **Procedures to take in an emergency**

Medication administered by	**Date and time**

CONTACT DETAILS	
Name:	Telephone Number:
Relationship to pupil:	Mobile Telephone Number:

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.

Signed: Date:

Relationship to pupil:

Medication administered by	Date and time