REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the appointed member of staff has agreed to administer the medication.

CHILD DETAILS

Surname:		**Male/Female:**	
Forename :		**Date of Birth:**	
Address:		**Registration Group:**	
Condition or Illness:			

MEDICATION

Name/Type of Medication (as described on the container)			
For how long will your child take this medication?			
Date dispensed		Full directions for use *continue overleaf if need more space*	
Dosage and method		Timing	
Special precautions		Side effects	
Self Administration			
Procedures to take in an Emergency			

PARENT/CARER CONTACT DETAILS

It is the parents responsibility to check medicines are in date

Name:		Daytime Tel No:	
Relationship to child:			
SIGNED BY PARENT/CARER:			
PRINT NAME:		**DATE:**	

	FOR OFFICE USE ONLY
TEACHER & OFFICE INFORMED:	
HEADTEACHER APPROVAL:	

DATE MEDICINE ADMINISTERED	TIME	ADMINISTERED BY	WITNESSED BY