**REQUEST FOR SCHOOL TO ADMINISTER MEDICATION**

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| *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 medicine.* |
| **Details of pupil** |
| **SURNAME:** |  |
| **FORENAME(S):** |  |
| **FORM:** |  |
| **ADDRESS:** |  |
|  |
| **DATE OF BIRTH:** |  |
| **MALE OR FEMALE:** |  |
| **CONDITION OR ILLNESS:** |  |
| **Medication** |
| *Parents must ensure that medication supplied is ‘in date’ and properly labelled* |
| **NAME/TYPE OF MEDICATION:****(as described on the container)** |  |
| **DATE DISPENSED:** |  |
| **EXPIRY DATE:** |  |
| **FULL DIRECTIONS FOR USE, INCLUDING DOSAGE AND METHOD:***(N.B. Dosage can only be changed on a Doctor’s instructions)* |  |
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| **TIMING:** |  |
| **SPECIAL PRECAUTIONS:** |  |
| **ARE THERE ANY SIDE EFFECTS THAT THE SCHOOL NEEDS TO KNOW ABOUT?:** |  |
| **SELF ADMINISTRATION:** | **YES □ NO □** |
| **PROCEDURES TO TAKE IN AN EMERGENCY:** |  |
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| **Contact Details** |
| **NAME:** |  |
| **PHONE NO:** | **Home:** |
| **Mobile:** |
| **Work:** |
| **RELATIONSHIP TO PUPIL:** |  |
| **ADDRESS:** |  |
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| *I understand that I must deliver the medicine personally to the Office Manager 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:** |  |

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| **FOR OFFICE USE ONLY** |
| **NAME OF PUPIL:** |  |
| **QUANTITY AND NAME OF MEDICATION TO BE RECEIVED:** |  |
| **TIME THE MEDICATION IS TO BE ADMINISTERED (e.g. break/lunchtime)** |  |
| **CHILD WILL BE SUPERVISED BY:**  |  |
| **THIS ARRANGEMENT WILL CONTINUE UNTIL: (either end date of course of medicine or until instructed by parents)** |  |
| **School agrees that the pupil named above will receive the medicine as detailed above.** |
| **SIGNED (Office Manager):** |  |
| **DATE:** |  |
| ***The original should be retained on the school file and a copy sent to the parent/carer to confirm the school’s agreement to the named pupil carrying his/her own medication*** |