MED 1

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Head Teacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Surname: .....

Forename(s): .....

Address: ..... M/F: .....

..... Date of Birth: .....

..... Class/Form: .....

Condition or illness: .....

MEDICATION

Prescribed Medication □

Non-Prescribed Medication □ *I confirm that my child has had this medication previously with no ill effects* □

Name/Type of Medication: .....
(as described on the 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: .....

CONTACT DETAILS

Name: ..... Daytime Telephone No: .....

Relationship to pupil: .....

Address: .....

.....

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

Date: ..... Signature(s): .....

.....

Relationship to pupil: .....

MED 2

Medical Condition: .....

Date	Time	Name of Medication	Dose Given	Any Reactions	Signature of Staff	Print Name