MED1
(Ongoing Meds)

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.

DETAILS OF PUPIL

Surname: _____

Forename: _____

Class: _____ Date of Birth: _____

Address: _____

_____

CONTACT DETAILS

Name: _____

Relationship to child: _____

Contact Telephone Number: _____

MEDICATION

Name of medication	
Date prescribed	
Expiry date	
When to be taken	
Dosage and method	
Special Precautions	
Side Effects	
Self Administration?	Yes / No
Procedures to be taken in an emergency	

It is your responsibility to replace the medicine when it is close to the expiry date.

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.

Signed: _____ Date: _____