

## REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Parents must complete this form if they wish the school to administer medication.

Please Note: The school will not give your child medicine unless you complete and sign this form. **The medicine must be prescribed by a doctor, be in the original container and must have the prescription label stating your child's name, dosage and expiry date.**

### DETAILS OF PUPIL

**Surname:** \_\_\_\_\_ **Forename:** \_\_\_\_\_

**Male / Female** (*Delete as appropriate*) **D.O.B.:** \_\_\_\_\_ **Class:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Condition:** \_\_\_\_\_

### DETAILS OF MEDICATION

<u>Name of Medicine</u>	<u>Date Prescribed</u>	<u>Duration of Treatment</u>	<u>Dosage and Method</u>	<u>Timing</u>	<u>Self-Administer Yes/No</u>

Side effects from medication: \_\_\_\_\_

Emergency Procedures: \_\_\_\_\_

### CONTACT DETAILS

**Name:** \_\_\_\_\_ **Daytime Telephone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

### DECLARATION

I understand that I must deliver medicine personally to the School Office and accept that this is a service that school is not obliged to undertake.

**Signed:** \_\_\_\_\_ Parent/Guardian **Date:** \_\_\_\_\_

**Relationship to child:** \_\_\_\_\_

