REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form.

All information will be treated confidentially.

PUPIL NAME ……..

Date of Birth …… CLASS ……..

CONDITION OF ILLNESS ……..

Name/Type of medication …….

Dosage and method ……

When/time to be given/administered ……

Period for which medication is required ……

Special precautions/side effects ……

……

PARENT/CARER CONTACT DETAILS (if different to what has already been provided)

Name ……. Relationship to pupil ……..

Contact number …….

I understand that the medicine must be delivered personally to the office and accept that this is a service which the school is not legally obliged to undertake.

SIGNATURE …… DATE ……

This form will be stored securely in the staffroom, with the medication. It will be held securely in accordance with Data Protection legislation. For temporary medication administration, this form will be shredded following completion of the final administration.