



## REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

*Form to be completed by parents if they wish the 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.

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### DETAILS OF PUPIL

Surname:

Forename(s):

Date of Birth:

Class:

Condition or illness:

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### MEDICATION

Name/type of medication (as described on the container)

For how long will your child take this medication:

Date dispensed:

**Full directions for use:**

Dosage and method:

Timing:

Special precautions:

Side effects:

Self administration:

Procedures to take in an emergency:

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### CONTACT DETAILS

Name:

Daytime telephone no:

Relationship to pupil:

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

Date:

Signature(s):

Relationship to pupil: