PRESCRIBED MEDICATION ONLY **MED 1A**

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form.
It is at the Headteacher's discretion that school staff are able to administer this medication.

PUPIL DETAILS

Name ______________________ Class __________

Address ______________________

Date of birth __________ Gender Male / Female * * delete as applicable

Condition or illness ______________________

MEDICATION

Name / Type of medication (as described on the container) ______________________

Date dispensed __________ For how long will your child take this medicine? __________

Dosage and method ______________________

At what time? __________ Self administration Yes / No *

Special precautions or side effects ______________________

Procedures to be taken in an emergency ______________________

CONTACT DETAILS

Name ______________________ Relationship to pupil __________

Address ______________________ Daytime phone no. __________

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

Signature ______________________ Date __________

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Date dispensed | For how long will your child take this medicine?
Dosage and method
At what time? | Self administration Yes / No *
Special precautions or side effects
Procedures to be taken in an emergency

CONTACT DETAILS

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