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**	