FORM 1

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Please note that the school will not administer medicine to your child unless you complete and sign this letter, and the Headteacher has agreed that the school staff can administer the medication.

Dear Headteacher

I request the administration of medicine to :

Pupils Details

Surname.....First Name.....

Male/Female.....Class.....Date of Birth.....

Address.....

.....

.....

Condition or illness.....

Medication

Name/Type of Medication (See container).....

For how long will this medicine be administered?.....

Date Dispensed.....

The above medication(s) have been/have not been* prescribed by a doctor. They are clearly labelled indicating contents, dosage and child's name in full.

*please delete as appropriate

Name of Prescribing Doctor.....

Address of Prescribing Doctor.....

PLEASE TURN OVER

Directions for Use

Dosage and Method.....

Times of Administration.....

Any special
precautions.....
.....
.....

Any possible side effects.....

Is supervised self administration possible.....

Contact Details

Name .....

Daytime Telephone Number.....

Mobile Telephone Number.....

Relationship to pupil.....

Address.....

.....Postcode .....

I understand that the medicine must be delivered personally to the school and that the school will only be able to administer the medicines if it can make the staff time available. I understand that I remain responsible for ensuring that my child receives administration if the school is unable to.

Signed.....

Address (if different from pupil address) :

.....
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.....Postcode .....Date.....

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For completion by the school

I agree to arrange for the administration of medicines requested by the parent.

Signed .....Date .....