Parental Request for School Administration of Medication

(Please enter information into the shaded areas)
(This sheet might need to be repeated if the child/ young person has multiple health care conditions)

To: The Head teacher

School:

I request that my son/daughter is given the following medication or clinical test by school staff as indicated below:

Name of child	Date of Birth	Class/Teacher	Date request made

Name of medical condition	

Details of medicine(s) and/or test(s)

Name of medicine(s) or test(s)	Dosage	Time to be administered (am/pm)	Only as required (tick)
A			
B			
C			

Please indicate the circumstances in which the medicine(s) or test(s) should be administered and action to take if the child/young person refuses to take
A
B
C

I understand that:

- I will undertake to deliver the medicine(s) and/or test materials personally to school, and to replace them whenever necessary.
- I will advise you immediately of any changes in treatment prescribed by doctor or hospital.
- I must confirm that the **First Dose** of the medication has been given at home- **Excluding Emergency Medication**
- Staff within the school take responsibility for this on a voluntary basis and cannot take responsibility when my child/young person refuses to take medication

Signed by:	Relationship to child/young person:	Date:
Parent/Carer:		
School:		

RECEIPT OF MEDICATION FOR CHILD		
Name of medicine	Date received in school	Expiry Date
Total amount of drug received (in mls, no. of tablets or units)		

Name of school:	Signature of staff member	Countersignature of 2nd staff member

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Please note that medication stored in schools will not be available out with normal school hours.

Parents and carers must contact their GPs within normal hours for the replacement of medication out with normal school hours and terms