PERTH & KINROSS COUNCIL

Education & Children's Services

APPENDIX 1

SA

[redacted]

Parental request for medication to be self-administered

To: Head of Establishment.....

I wish my son/daughter ..... when necessary, to be permitted to take the following medicine(s).

(a) Name of medicine(s): .....

(b) By whom prescribed: (please tick as appropriate)

General Practitioner ☐ Hospital ☐ Other ☐

(c) Times at which medicine(s) to be taken and/or test(s) to be performed:

Set times (please specify) .....

.....

or when required .....

.....

(please indicate the circumstances in which the medicine(s)/test(s) should be used)

(d) Dose of medicine(s) to be given and means of administration and/or details of test:-

.....

.....

(e) Length of time current supply of medicine(s) will cover .....

(f) It is/is not essential for a member of staff to record each dose of medicine and/or each test performed.

(g) My son/daughter will carry the above medicine(s) at all times, for taking as required.

(h) My son/daughter can recognise when they need to take their medication.

(i) I undertake to advise you immediate of any change of treatment prescribed by my doctor or hospital.

Signature ..... Date .....
(Parent/Guardian)

Address .....

Daytime telephone no. .....