Parental Request for School to Administer Medication

The School will not give your child medicine unless this form is completed and signed

Pupil's Surname _____ Pupil's Forename _____

Address _____ Male/ Female

Date of Birth _____ Class _____

Condition / illness _____

Name/ Type of Medication (as described on container) _____

For how long will your child take this medication _____

Date(s) to be Dispensed _____

FULL DIRECTIONS FOR USE

Dosage _____ Timing _____

Route (oral/ injection etc) _____

Side Effects _____ Self Administer YES/NO

Procedures to take
In an emergency _____

Emergency
Contact Name _____

Relationship to Pupil _____ Tel No. _____

Address _____

Please read and sign this declaration:

I understand that:

1. **I must deliver medication personally to: _____ (staff member)**

2. **If no member of staff who is trained to give medicine is available the medicine will not be given and I will be informed**

Signature _____ Date _____

Relationship to Pupil _____

Administration of Medication Administered in School

Date	Pupil Name	Time	Name of Medication	Dose Given	Any Adverse Reaction	Signature of Staff Member