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 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 _____ Telephone number _____

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 _____

Record of Medication Administered In School

Date	Pupil Name	Time	Name of Medication	Dose Given	Any adverse reaction	Signature of staff member
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