## **MEDICATION IN SCHOOLS FOR PUPILS** NC

	REQUEST FOR SCHOOLS TO ADMINISTER MEDICATION
Pupils Details	

Pupil's name:	Date of Birth:	
Address:		
	Emergency Contact:	
Name of School: Class:		
Condition or Illness:		
Parental Request / Responsibility		
Please could you give my son/daughter the N Practitioner / Hospital Doctor.	Medicine which has been prescribed by the General	
I will personally arrange deliver of the med medicine to the school.	dicine or arrange with another adult to deliver the	
I will advise you immediately of any change o Practitioner / Hospital.	of treatment or medication prescribed by the General	
Please let me know if the medicine has not be	een given.	
I accept that this is a service the school is not	t obliged to undertake.	
Signature(s):	Parent/Carer Date:	
Signature of Child/Pupil:	Date:	
Details of Medication (to be completed by	General Practitioner / Hospital Doctor)	
Name of Medicine (as described on container	r)	
Date dispensed		
Medicine prescribed by (signature)		
(printed signature/stamp)	Hospital Doctor	
<b>Direction for use:</b> Please refer to label on medicine container a	nd act in accordance	
Dose of Medicine to be given		
Route of administration		
<ul> <li>Times at which medicine should be give</li> </ul>	n	
<ul> <li>Length of course (days)</li> </ul>		
Any other comments/side effects		
Self administration		

## This part of the form is to be completed by the school

Confirmation of the Head Teacher's agreement to administer medication

I agree that the named pupil may receive medication administered by a member of school staff, as prescribed by the General Practitioner/Hospital Doctor and requested by the parent/carer(s).						
Signature (Head Teacher)	Date					
RECORD OF MEDICATION ADMINISTERED IN SCHOOLS						
Name of Pupil						
Name of Medication						

NB Please use a separate form for each medication.

Date	Time	Dose	Any reaction / refusal (please comment)	Signature of staff member	Print name