REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will only administer medicines on receipt of this form being fully completed and signed.

DETAILS OF PUPIL

Name:.....

Address: ..... M/F: .....

..... Date of Birth: .....

..... Class/Form:.....

Condition or illness:.....

MEDICATION

Name/Type of Medication (as described on the container):.....

For how long will your child take this medication:.....

Date Dispensed: .....

Full Directions For Use:

Dosage and method: .....

Timing for medicine to be given at school:.....

Will a dose of medicine be given before school? ..... Time: .....

Special Precautions:.....

Side Effects:.....

Self Administration:.....

Procedures to take in an Emergency:.....

.....

CONTACT DETAILS

Name: ..... Relationship to Pupil:.....

Address: .....

..... Daytime Telephone No: .....

I understand that I must deliver the medicine personally to the school office.
I accept that this is a service which the school is not obliged to undertake and, as we are not health professionals, we cannot be held liable for mis-administration or non-administration.

Date:..... Signature:.....