REQUEST FOR SCHOOL TO ADMINISTER MEDICATION
For pupils requiring short term medication

1. Pupil's Information

Name: _____ Address: _____

Class: _____ _____

2. Are your emergency contact details up to date ☐ Yes ☐ No

If no please provide the following information

Name of emergency contact _____

Relationship to child _____ Daytime phone no. _____

3. Details of pupil's illness/condition _____

_____

4. Details of medication to be taken during school hours

Name/type of medication (as on container)

_____

_____

How long will the child be required to take the medication

_____

_____

Dose and method of administration
(the amount taken and how the medication is taken, eg tablets, inhaler)

_____

Date treatment started

_____

Frequency of dosage _____

When is it taken (time of day)

_____

Expiry date of medication

_____

Are there any side effects that could affect this pupil at School?

_____

_____

Additional intructions/information eg before/after food, storage

_____

_____

5. Permission

I understand that I must deliver the medicine personally to the school office and collect any remaining medication when the course is complete. I accept that the school has the right to refuse to administer medication.

Name: _____ Relationship to child: _____

Signed _____ Date _____

For School office use: Date medicine returned to parent _____

MedA/Jul17