EDWINISTREE MIDDLE SCHOOL
A Voluntary Controlled Church of England School

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Medication will not be administered unless prescribed by a doctor and all medication must be in the original container. Antibiotics will only be administered by school staff if it is prescribed to be taken 4 times a day.

DETAILS OF PUPIL

Surname:
……

Forename(s)
……

Date of Birth: ……. Male / Female

Address ……

…….. ……

……Tutor Group : ……..

Condition or illness……

MEDICATION

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

How long will your child take this medication?……

Date Dispensed ……Expiry Date: ……..

FULL DIRECTIONS FOR USE:

Dosage and Method ……

Timing…….. ……

Special Precautions ……..

Side Effects: ……..

Self-administration: YES / NO

Procedures to take in an Emergency ……

CONTACT DETAILS:

Name:……Daytime Telephone No……..

Relationship to student……

Address:
……

I understand that I must deliver the medicine personally to the school office and accept that this is a service which the school is not obliged to undertake.

Date:……Signature(s)……

Relationship to student:……