**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:……………………………………………………………………………………………………………………