REQUEST FOR THE SCHOOL TO MANAGE/ADMINISTER MEDICATION

PUPIL DETAILS:

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

Address: .....

Class .....

Condition or illness: .....

DETAILS OF MEDICATION:	
Name of Medication: **(This MUST be in the original container)**	
Date Dispensed:	
Expiry Date:	
How long should this medication be taken for?	
Doseage:	
Date and time of last dose:	
Method: (Spoon/tablet/inhaler)	
Timing:	
Administered by:	Child / Member of staff (delete as appropriate)
Likely side effects:	

DETAILS OF G.P:

Name: ..... Surgery .....

Telephone Number: .....

EMERGENCY CONTACT DETAILS:	
Name:	Daytime Contact Number:
Relationship to child:	
Address (if not child's home)	

DECLARATION:

I understand that it is my responsibility to deliver the above medication to the school office, in person and to collect it every afternoon/at the end of the treatment. N.B Medicines **CANNOT** be collected by anyone under the age of 18. I understand that the school will do is best to ensure the medicine is administered as described above but appreciate that this is a service voluntarily undertaken by the school staff who have no medical qualifications apart from First Aid.

Signed: ..... Date: .....

Parent/Guardian