REQUEST FOR SCHOOL TO SUPERVISE SELF ADMINISTRATION OF MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Headteacher has agreed that school staff can supervise the self administration of the medication.

DETAILS OF PUPIL

Surname:_____

Forename:_____

Date of Birth: _____ Class: _____

Condition or illness:_____

MEDICATION

Name of medication: _____

NOTE: MEDICATION MUST BE IN AN APPROPRIATE NAMED CONTAINER

For how long will your child take this medication? _____

FULL DIRECTIONS FOR USE:

Dosage: _____

Timing: As and when required/_ _ _ _ _ _ _ (Time)

Special precautions/side effects:_____

Procedures to take in an emergency:_____

CONTACT DETAILS:

Name: _____

Relationship to the pupil:_____

Daytime telephone No._____

I understand that I must deliver the medicine personally to a member of teaching /office staff and accept that this is a service which the school is not obliged to undertake. I will inform the school immediately in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature: _____

Parent/Guardian

Date:_____