Request for School to Administer Medication

We will not be able to give your child medication unless you complete and sign this form. Thank you.

Name and DOB of child ……

Class ……

Condition or illness ……

Medication & length of time left for your child to take this medication ……

Dosage and timings ……

Medication prescribed by GP? Yes ☐ No ☐ (Please tick)

Any precautions ……

Procedures to take if there is an emergency ……

Contact details (Name and phone number) ……

I UNDERSTAND THAT I MUST DELIVER AND COLLECT THE MEDICINE PERSONALLY FROM THE SCHOOL OFFICE

Signed …… Date ……

Relationship to Pupil ……

Staff signature (on receipt of meds) ……