ST PETER'S RC PRIMARY SCHOOL

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Form for parents to complete if they wish the school to administer <u>prescribed medication</u>

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

DETAILS OF PUPIL

Surname:_____

Forename(s):_____

Address_____

_____Postcode_____

Date of Birth_____ Year Group/Class_____

Condition/Illness_____

MEDICATION

Name/Type of medication (as described on the container)_____

Duration of course_____

Date dispensed_____

FULL DIRECTIONS FOR USE OF MEDICATION:

Dosage and method_____

Time to be administered by school_____

Special precautions_____

Side effects_____

Self administration_____

Procedures to take in an emergency_____

CONTACT DETAILS

Name_____Tel No_____

Relationship to pupil_____

Address_____

_____

I understand that I must deliver the medicine personally to (agreed member of staff) and accept that this is a service which the school is not obliged to undertake.

Signed_____Dated_____