REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Pupil's Full Name: …… Class: ……

Address: ……

Condition/Illness: ……

Name/Type of Medication: ……

Date Dispensed: ……

Frequency of Dosage: …… Timing: ……

Additional instructions/information (eg before/after food, interaction with other medicines, possible side effects, storage instructions):……

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Emergency Contacts:

Name: …… Relationship to Child: ……

Daytime telephone number: ……

OR

Name: …… Relationship to Child: ……

Daytime telephone number: ……

I understand that I must deliver the medicine personally to a member of staff and collect any remaining medication when the course is completed. I accept that the School has the right to refuse to administer medication.

Signed: …… Name: ……

Relationship to Child: …… Date: ……

School Use:
Remaining medication returned to parent on (date): ……

Or disposed of via: …… *on (date):* ……