EGREMONT PRIMARY SCHOOL
REQUEST FOR SCHOOL TO ADMINISTER 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 administer the medication

DETAILS OF PUPIL

Surname:_____

Forename(s)_____

Address:_____M/F:

_____Date of Birth:

_____Class/Form:

Condition of illness:_____

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

For how long will your child take this medication:_____

Date dispensed:_____

Full Directions for use:

Dosage and method:_____

Timing:_____

Special Precautions:_____

Side Effects:_____

Self Administration:_____

Procedures to take in an Emergency:_____

CONTACT DETAILS:
Name:_____Daytime Telephone 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.

Date:_____Signature(s):_____

_____

Relationship to pupil:_____