Request for School to Administer Medication

If you wish the school staff to administer medication to your child, please complete and sign this form, thank you.

DETAILS OF PUPIL

Child's name: ……

Class: …… DOB: …….

Condition or illness: ……..

MEDICATION

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

For how long will your child take this medication: ……..

Date dispensed: ……..……

Full Directions of use:

Dosage and method: …….

Timing: …….

Special Precautions: …….

Side Effects: …….

Self Administration: …….

Procedures to take in an emergency: ……

CONTACT DETAILS:

Name: …… Relationship to Pupil: …….

Daytime Telephone No……..

I understand that the medication will be administered by a member of staff at the appropriate time.

Signature (s): ……. Date: ……

Relationship to pupil: ……..

OFFICE USE

Medicine is in: School Office ☐ Staffroom Fridge ☐