



Parental request for school to administer medicine

- I understand this is a service that the school is not obliged to undertake.
- I understand I must deliver the medicine personally to a member of the Office staff.
- I understand that I must notify the school of any changes in writing.
- I understand that school staff may need to arrange a meeting to discuss your request.

Name of Child		Date of Birth	
Class		Year	
Medical condition/illness			
Medicine Name/Type of Medicine (as described on the container)			Storage Refrigerator needed Yes/No
Date dispensed		Expiry date	
Dosage and method		Self Administration	Yes/No
Timing/s			
Start date:		End date or review date	Enter date and delete as appropriate
Possible side effects			
Procedures to take in an Emergency			
Known triggers / Any other information			

Please give any other information on a separate sheet. Sheet attached Yes/No

Contact Details

Name: Relationship to Child:.....

Address:

Daytime Telephone No:..... Date:

Signature(s):

School Acceptance

School agrees to this request and will do everything reasonably possible to ensure that the medication is administered according to the above information.

Signed: Date:
(Headteacher/Deputy)

For School Use	Seen by	CT	TAs	DH	HT	SLS	OFF	Other-
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