

Parental request for school to administer medicine

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| Name of child |  |
| Date of birth |  |
| Class |  |
| Medical condition/illness(reason for needing medicine) |  |
| Name of medicine |  |
| Date dispensed |  |
| Expiry date |  |
| Date for final dose at school |  |
| Dose to be given and method eg spoon, syringe, with water. |  |
| Times to be given |  |
| Special precautions |  |
| I understand that I must deliver the medicine personally to the school office and that I am responsible for collecting the medication at the end of the day or when the last dose has been administered. I will also permit you to administer any non- prescribed (over the counter medication ) which I request and understand that this is at the discretion of the Head of School .I will also inform the class teacher verbally or by using the PAL, that my child will be taking medication. |
| **Contact Details** |
| Name of contact |  |
| Daytime telephone number |  |
| Relationship to child |  |
| I accept that this is a service that the school is not obliged to undertake. I understand that I must notify the school office, in writing, of any changes to the administration of this medicine. I confirm that my child is not allergic to any medicine, prescribed or non - prescribed which I have asked school to administer.Date: Signature: |