

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: | | |