Hurst Hill Primary School

OFFICIAL

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form. School will only administer prescribed medication.

PUPIL DETAILS

Surname:_____ Forename(s):_____ Class:_____

Male / Female (please delete as appropriate) Date of Birth: _____

Address:_____

_____

Condition of illness:_____

MEDICATION DETAILS

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

Date Dispensed _____ Expiry Date _____

For how long will your child take this medication: _____

Dosage and method: _____ Timing: _____

Time last dispensed:_____

Special Precautions:_____

Are there any side effects that the school should know about:_____

Any other Medical Conditions that we should know about:_____

Self Administration: Yes / No (please delete as appropriate)

Procedures to take in an emergency:_____

CONTACT DETAILS

Name: _____

Telephone Number:_____

Relationship to pupil:_____

Address:_____

I understand that I must deliver the medicine personally to a member of staff and I accept that this is a service the school is not obliged to undertake.

I understand that I must notify the school of any changes in writing.

Signed: _____ Date:_____

Relationship to pupil:____