

# Scissett CE Academy

## MEDICAL FORM

**TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD TO WHOM DRUGS MAY BE ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF.**

If you need help to complete this form, please contact the School or the Health Visitor attached to your doctor's surgery.

Name of Child ..... Date of Birth .....

Address.....

Parents Name .....

Parents Address .....

Doctor ..... has prescribed (as follows) for my child.

or

This is an over-the-counter medicine which I wish to be administered to my child.

Name of Drug or Medicine? .....

How often (eg. *Lunchtime*)? .....

How much (eg. *half a teaspoon*)? .....

When (eg: before or after food)? .....

Any special circumstances:- (describe what circumstances, and the nature and dosage of the medication or treatment):-

I request that the treatment be given in accordance with the above information by the Head Teacher or a qualified first-aider. I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.

I undertake to supply the school with the drugs and medicines in properly labelled containers, which I will give to the Head Teacher.

I accept that the school staff will do their best to administer the medication as requested, and accept staff cannot be held responsible for any problems which arise from administering the medication or for failing to administer the medicine correctly.

Signed .....

Date .....

Ami/pupil/medica