FOUNTAIN PRIMARY SCHOOL

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

1) Details of Pupil

Surname _____

Forename _____ Gender Male / Female

Address _____ Date of birth _____

_____ Class _____

Post code _____

2) Medication

Condition or Illness _____

Name of Medication _____

How many days is the medication to be given for? _____

Date from _____ to _____

3) Directions

Dosage _____

Time _____ (Medication will be given before lunch unless otherwise stated.)

Notes _____

4) Contact Details

Name _____ Daytime telephone number _____

Relationship to pupil? _____

Address (if not the one above) _____

_____

The school will not give your child medication unless you have completed and signed this form.
By signing I agree to these arrangements and absolve the school of any responsibility for any adverse reactions the child may have to the medication and from my child refusing to take the medication.

Signature of parent/Carer ……

Date ……

Date	Time	Dose	Signature 1	Signature 2