Warley Primary School

Request for school to administer medication

Pupil's Full Name: _____

Class/Form: _____

Address:

_____

_____

Condition/Illness: _____

Type of medication: _____

Length of course: _____ Date treatment started: _____

Dosage: _____ Frequency of dosage: _____

Timing: _____

Additional instructions/information (e.g. before/after food, with another medicine, side effects, storage, right/left eye only, right/left ear only):

_____

_____

Emergency contacts

Name: _____ Relationship to child: _____

Daytime telephone no.: _____

OR

Name: _____ Relationship to child: _____

Daytime telephone no.: _____

I understand that I must deliver the medicine personally to (agreed member of staff) and collect any remaining medication when course completed. I accept that the school has a right to refuse to administer medication.

Name: _____ Relationship to child: _____

Signed: _____ Date: _____

School use

Remaining medication returned to parent on (insert date): _____

Record for medication administered to pupils

Date	Time	Pupil's Name	Name of medication and reason	Dose given	Signed

Where paracetamol is administered, please also give reason.

Name of person responsible for administering medication: _____

Deputy (in case of absence): _____