REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Form for parents to complete if they wish the school to administer medicine

HERMITAGE PRIMARY SCHOOL **Head Teacher –**

The school will not give your child medicine unless you complete and sign this form, and school staff agree to administer the medication.

Details of Pupil

Surname:		Forename(s):			
Address:					
Date of Birth:		Gender:		Class:	
Condition or Illness:					

Medication 1: *Parents **must** ensure that medication supplied is in date and is properly labelled with a Pharmacy or Dispensed label which states:*

- *Pupil's Name*
- *Name of medicine*
- *Dose*
- *Frequency of administration*
- *Date of dispensing*

Name/type of medication:				
How long will your child take this medication?				
Quantity:				
Full directions for use: *Note dosage and method e.g. Oral, Injection, Tube Feed, or other* **N.B. "As directed " is not acceptable**	Method e.g. oral:			
	Time when medicine should be given:			
	Special precautions:			
	Side effects:			
Self Administration:	Yes		No	

P.T.O

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION (continued)

PROCEDURES TO FOLLOW IN EN EMERGENCY:

Contact 1

Name:	
Emergency phone number:	
Relationship to pupil:	

Contact 2

Name:	
Emergency phone number:	
Relationship to pupil:	

- *I understand that I must deliver the medicine personally (to agreed member of staff) and accept that this is a service which the school is not obliged to undertake.*
- *I undertake to inform the agreed member of staff immediately of any changes in the medication and provide an appropriately labelled supply.*
- ***Please Note: Verbal information will <u>not</u> be acted upon.***
- *Medicines will be replaced / replenished by me as required and I understand and agree that the school are not responsible for ensuring supply of the medication.*

Signature(s): _____ Date: _____

Relationship to pupil: _____

FOR OFFICE USE ONLY

Date	Dose	Time	Check date of dispensing /expiry is valid – please tick	Signature of staff member