Warden House Primary School

Request for School to Administer Medication

The school will not give your child medicine unless you complete and sign this form and the Principal has agreed that school staff can administer the medicine.

Pupil's name _____ **Class**_____

Address _____

_____

Condition or illness _____

Medication

Name and type of medication _____

Date dispensed _____ **Expiry date**_____ **Dispensed by**_____

Please ensure the medication is in its original packaging displaying pupil's name and prescribing doctor.

For how long will your child take this medication? _____

FULL directions for use:

Dosage and method _____

_____

Timings _____ **Self-administration** **YES/NO**

Special precautions _____

Side effects _____

Procedures to take in an emergency _____

Contact details

Name _____ **Relationship to pupil**_____

Address if different from above _____

_____ **Tel:** _____

I understand that I must deliver the medicine to the school office and accept this is a service which the school is not obliged to undertake.

Signed _____ **Name** _____ **Date** _____

Authorised to give by Principal _____ **Date** _____

To be completed by a member of staff

Pupil's name _____ **Class** _____

Medicine received by _____ **Date** _____

Medication Type	✔
Tablets	
Medicine	
Other (please state)	

To be stored in	✔
First Aid Box (in classroom)	
First Aid cupboard (in First Aid Room)	
Fridge (First Aid Room)	

Dosage given at:

Date/Time _____ **Amount** _____ **Given by** _____

Date/Time _____ **Amount** _____ **Given by** _____

Date/Time _____ **Amount** _____ **Given by** _____

Date/Time _____ **Amount** _____ **Given by** _____

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