

PRIOR'S MILL C.E. CONTROLLED
PRIMARY SCHOOL



Request for the school to Administer Medication Form

The school will not give your child medicine unless you complete and sign this form

Surname: _____

Forename: _____

Address: _____ M/F: _____

_____ Date of Birth: _____

Condition or illness : _____

Medication

Name/Type of Medication (as described on the container) _____

For how long will your child take this medication: _____

Date dispensed: _____

Full Directions for use:

Dosage and method _____

Timing: _____

Side effects: _____

Procedures to take in an Emergency: _____

CONTACT DETAILS

Name: _____ Daytime telephone no: _____

Relationship to Pupil _____

Address: _____

I understand that I must deliver the medicine personally to either my child's class teacher/the Head Teacher or school office and accept that this is a service which the school is not obliged to undertake. I take full responsibility if the medication provided is not in the original container, labelled by the pharmacy with the student's name, prescriber's name, name of medication, dosage, route, conditions for storage, prescription date, and expiration date.

Date: _____ Signature: _____

Relationship to pupil: _____

