Form: AM2

REQUEST FOR SCHOOL TO ADMINISTER MEDCATION

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

DETAILS OF PUPIL

Surname: .....

Forename(s): .....

Address: ..... **M/F:** .....

..... **Date of Birth** .....

..... **Class/Form** .....

Condition of 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: .....

Special Precautions: .....

Side Effects: .....

Self Administration .....

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 (agreed member of staff) and accept that this is a service which the school is not obliged to undertake.

Date: ..... **Signature(s):** .....

Relationship to Pupil: .....