Preston & Wingham Primary Schools Federation

Request for School to Administer Medication

Please complete this form if you would like the school to administer medication to your child and hand it to the school office. The school will not give your child medication unless you complete and sign this form. A new form must be completed if <u>any</u> of the details change.

DETAILS OF PUPIL	_		
Surname:	Forename:		_
Date of Birth:	Male/Female: Year	Group/ Class:	
Medical Conditions or Illness _			
DETAILS OF MEDICATION			
Name/Type of Medication: (as described on the container)	 		
Expiry Date			
Full Directions for use:			
Storage Instructions			
Dosage and method:			
Self Administration Y / N			
Timing:			_
Procedures to take in an emerg	ency:		
EMERGENCY CONTACT DETA	AILS:		
I understand that I must delive that this is a service which the administer the medication but medication we advise that you a medicines should only be taken Written permission to administed medication must be in the origin Written consent must be receare instructed by the Local Autit has been prescribed by a doc	e school is not obliged to und cannot guarantee to do so. I make arrangements to visit sch during the school day when esseter medication must be reconal container, with prescriber's ived before staff can administer medication reconstitutions.	lertake. The school will if it is essential that yo nool to administer the mo sential. eived before the school s instructions. ter paracetamol based r	make every effort to our child receives the edication. Prescription of can do so and the nedications, but staff
Signature:	Da	te:	_
Relationship to pupil:			

<u>Date for review to be initiated by Parent should medical condition, illness or medication change</u>

MEDICATION ADMINISTRATION RECORD

DATE	MEDICATION	TIME	DOSAGE	ADMINISTRATOR