Request for Administration of Medicine

ALL MEDICINE TO ENTER SCHOOL THROUGH THE OFFICE

Childs Full Name:	
Class:	
Date of Birth:	
Home Address:	

Emergency Contact:	
Home Tel:	
Work Tel:	
Mobile No:	

GP Surgery:	
GP Tel No:	

Reason for medication:	
Name & Strength of Medicine:	
Dose & Frequency:	
Expiry Date:	
Course Completion Date:	

Special Instructions:	Allergies:

Please read carefully and tick appropriate boxes:

My Child will be responsible for the self-administration of medicines as directed above.	
I agree to members of staff administering medicines as direced above.	
I recognise that staff are not medically qualified.	

Signed (parent/guardian): _____ Date: _____

Staff signature: _____ Date: _____

Office Use Only.

	✓	Staff Name & Signature	Date
Medication received and checked			
Medication entered onto tracker			
Scholarpack updated			
Medication secured in First Aid Room			
Medication sent to class (with master copy)			
Copy of this form on file			