Great Bardfield Primary School

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Pupil's Full Name:…………………………………………………….. Class:………………………

Address:……………………………………………………………………………………………..

Condition/Illness:…………………………………………………..…………………………..

Name/type of Medication:…………………………………………………..…………………

Date Dispensed:……………………………………………………………………………..………

For how long will child be required to take medication?..

Dosage (eg. 5 ml):**……………….. Frequency of Dosage:………………………………………..**

Timing:………………………………………………………………………………………………

Additional instructions/information: (eg. Before/after food, interaction with other medicines, possible side effects, storage instructions) **……………………………………………………..**

……………………………………………………………………………………………………..

……………………………………………………………………………………………………..

Emergency contacts:

Name:……………………………….… Relationship to child:……………………..………………….

Daytime telephone no:……………………………………………………………………………..

OR

Name:………………………………….Relationship to child:……………….……………………..

Daytime telephone no:……………………………………………………………..………………

I understand that I must deliver the medicine personally to the Headteacher and collect any unused Medication when the course is completed. I accept that the School has the right to refuse to Administer medication.

Name:………………………………….Relationship to child:………………..…………………

Signed:……………………………………………………Date:…………………...………………..

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School use:
Remaining medication returned to parent on (insert date):…………….………………………….

or disposed of via………………………………………on…………………………………….

Mar. 04