



FORM MED 1

REQUEST FOR SCHOOL TO ADMINISTER PRESCRIBED MEDICATION

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: _____ Male/Female: _____

_____ D.O.B: _____

_____ Class: _____

Condition: _____

MEDICATION

Name of Medicine	Duration of Course	Dosage and method	Timing	Self-Administer (y/n)	Date prescribed

Side effects from medication: _____

Emergency Procedures: _____

CONTACT DETAILS

Name: _____

Daytime Telephone No: _____

Address: _____

Relationship to pupil: _____

DECLARATION

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.

I confirm that my child's Doctor has stated that (s)he considers it is necessary for the medication to be taken during school hours.

Signed: _____

Parent/Guardian

Relationship to Pupil: _____

Date: _____