



## Request for school to administer 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.

A newly completed form should be submitted every time the dosage or timings of medication are changed. Please read and sign the disclaimer at the end of the document.

### **DETAILS OF PUPIL**

Surname: \_\_\_\_\_

Forename(s): \_\_\_\_\_

Address: \_\_\_\_\_ M/F: \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Class/Form: \_\_\_\_\_

Condition or illness: \_\_\_\_\_

### **MEDICATION**

Name/type of medication (as described on the container)

\_\_\_\_\_

Date dispensed: \_\_\_\_\_

### **Full Directions for use:**

Dosage and method:

\_\_\_\_\_

Timing:

\_\_\_\_\_

Special Precautions:

\_\_\_\_\_

Side Effects:

\_\_\_\_\_

Self-Administration:

\_\_\_\_\_

Procedures to take in an Emergency:

\_\_\_\_\_



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### **CONTACT DETAILS:**

Name: \_\_\_\_\_ Daytime Tel No: \_\_\_\_\_

Relationship to Pupil:

\_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_

My child's doctor has prescribed the above medication. I understand that I must deliver the medicine personally to an agreed member of staff. I understand that this is a service which the school is not obliged to undertake.

Date: \_\_\_\_\_ Signature(s): \_\_\_\_\_

\_\_\_\_\_

Relationship to pupil:

\_\_\_\_\_

### **Legal disclaimer**

I understand that neither the Headteacher nor anyone acting on his/her authority, nor the Governing Body, nor Suffolk County Council will be liable for any illness or injury to the child arising from the administering of the medication or drug unless caused by the negligence of the Headteacher, the person acting on his/her authority, the governing Body, or Suffolk County Council, as the case may be.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to pupil \_\_\_\_\_