

**SHERINGHAM WOODFIELDS SCHOOL**  
**FORM: SWS 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 head teacher has agreed that school staff can administer the medication.

**DETAILS OF PUPIL**

Name: ..... DOB: ..... Class: .....

Condition or illness: .....

**MEDICATION**

Name of medication	Duration of course	Dosage and method	Timing	Self administer Y or N	Date prescribed

Side effects from medication:

.....  
.....

Emergency procedures:

.....  
.....

**CONTACT DETAILS**

Name: .....

Address: .....  
.....

Daytime telephone number: .....

**DECLARATION**

I understand that I must deliver the medicine personally to the transport assistant 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: ..... Date: .....

Relationship to pupil: .....