FORM 2

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.

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)

_____

For how long will your child take this medication: _____

Date dispensed: _____

Use by Date: _____

Full Directions for use:

Dosage and method: _____

Timing: _____

Special Precautions:
_____

Side Effects:
_____

Self-Administration: _____

Procedures to take in an Emergency:

_____

CONTACT DETAILS:

Name: _____ Daytime Tel No: _____

Relationship to Pupil: _____

Address:

_____

_____

I understand that I must deliver the medicine personally to the class teacher.

Date: _____ Signature(s): _____

_____

Relationship to pupil:

_____

Please also complete details on Form 2A below for staff to sign.

FORM 2A

I agree that _____will receive _____ every day at _____.

_____ will be given/supervised whilst he/she takes their medication by a member of the teaching staff. This arrangement will continue until _____.

Date: _____

Signed: (Supervising Teacher)

_____

_____