Parent/Guardian request to administer medication

Name of child ……..

Form ……Date of Birth.....

Known condition or illness ……..

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

Name of prescribing doctor & phone no. ……..

For how long will your child take this medication? ……..

Date dispensed ……

Method of storage ……

Expiry date……..

Dosage & method ……

Timing ……

Special precautions ……..

Side effects ……..

Procedures to take in an emergency……

Any other instructions ……

I understand that I must deliver the medicine personally to Mrs Lisk and accept that this is a service which the school is not obliged to take. The above information is accurate to the best of my knowledge at the time of writing and I give consent to the school to administer the medication in accordance with the School's policy. I will inform the School in writing of any changes to the above information.

Signed .....

Name ……

Relationship to pupil ……

Date ……