Private and Confidential

Request to Store/Administer Medication in School

Pupil's Name _____ Date of Birth _____

Pupil's Form Class _____

Condition or Illness_____

Medicine

Name/Type of medication as described on the packaging.	
How long will the medication need to be administered?	
Quantity of medicine provided to the school.	
Date medication provided to the school	

Full directions for use:

Dosage and method of administration						
Time of administration						
Side effects						
What should we do if we notice any side effects?						
Self-administration (Please tick as appropriate)	Yes (supervision not required)		Yes (only under supervision)		No (Only to be administered by a member of staff)	

Agreement

I understand that I must deliver the medicine personally to (agreed member of staff) and accept that this is a service that the school is not obliged to undertake.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering the medication in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medication is stopped.

Parent/Guardian's Signature _____Date _____