MERSEA ISLAND SCHOOL

Request to school to administer 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

Full Name: ……..

Address: ……

……..

……..

M/F Date of Birth: …….. Class: …….

Condition or illness: ……..

MEDICATION

Name/Type of Medication (as described on the container)……

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

Date Dispensed: ……

Full directions for use:

Dosage and method: …….

Timing: …….

Special precautions: …….

Side effects: ……..……..

Self administration: ……

Procedure to take in Emergency: ……..……..

CONTACT DETAILS:

Name: …… Daytime Telephone No: ……..

Relationship to Pupil: …….

Address: ..……

I understand that I must deliver the medicine personally to Mrs A Lancefield or nominated person and accept that this is a service which the school is not obliged to undertake.

Signed: …….. ParentCarer Dated: ……..