REQUEST FOR MEDICATION TO BE SELF-ADMINISTERED

MED 2

The school will not give your child medication unless you have completed and signed this form and the Head Teacher has agreed that school staff can administer the medication.

1. DETAILS OF PUPIL

Pupil's name:	Date of birth:
Address:	
School:	Class:
Tel No - Home:	Emergency:

2. DETAILS OF MEDICATION

Conditions or illness:	
Name/type of medication (as described on the container)	

Prescribed by: (Please tick as appropriate)

	GP	Name:
		Address:
	Hospital	Name:
		Address:
	Other	Name:
		Address:

For how long will your child take this medication?	
Full directions for use:	
Dosage and method:	
Times at which medicine/s to be given:	
Special precautions:	
Side effects:	

Procedures to be taken in an emergency: (eg asthma – maximum number of doses to be administered for treatment of acute wheezing)

3. PARENTAL RESPONSIBILITY

(i) I request that my son/daughter keep his/her medication on him/her for use as necessary.

(ii) I understand that I must deliver the medicine/s personally to you and to replace them wherever necessary.

Delete (i) or (ii) as appropriate

(iii) I accept responsibility for advising you immediately of any change of treatment prescribed by any doctor or hospital.

Signature: (Parent/Carer)	Date:
Signature: (Pupil)	Date:

Date received by school:	Signature of Head Teacher:

ACTION TAKEN: