Ashleworth CofE Primary School Request for School to Administer Medication

The school will not give your child medication unless you complete and sign this form, and the Headteacher has agreed that the school staff can administer the medication

Details of Pupil

Pupils Name _____
Date of Birth _____
Address _____
Condition or Illness _____

Medication

Name/Type of Medicine (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 _____
Procedures to take in an emergency _____

Contact Information

Name _____
Daytime telephone number _____
Relationship to pupil _____
Address _____

I understand that I must deliver the medicine personally to Mrs Kelly and accept that this is a service which the school is not obliged to undertake.

Signed_____ Date_____

Ashleworth CofE Primary School Confirmation of Headteacher's Agreement to Administer Medication

---

I agree that:

Pupils Name_____

Will receive (quantities and name of medicine)_____

_____

Every day at_____(time to be administered)

Name of Child_____ Will be given/supervised

Whilst he/she takes their medication by_____(name of staff)

This arrangement will continue until (either the end of the course of medicine or until instructed by their parents)

Signed_____(Headteacher) Date_____