

Administration of Medicine Form (2 pages)

(One form to be completed for each medicine)

The school will not give your child medicine unless you complete and sign this form.

School		
Pupil Name & Address		
Date of Birth		
Class		
Medical Diagnosis or condition		
Contact Information Family Contact No.1	Family Contact No.2	
Name _____	Name _____	
Telephone (mobile) _____	Telephone (mobile) _____	
Telephone (home) _____	Telephone (home) _____	
Telephone (work) _____	Telephone (work) _____	
Relationship to child _____	Relationship to child _____	
Clinic/ Hospital Contact	GP Contact	
Name _____	Name _____	
Telephone _____	Telephone _____	
Describe medical needs and give details of child's symptoms		
Daily care requirements (e.g. before sport/ lunchtime)		
Describe what constitutes an emergency for the child and the action to take if this occurs		

Medicine: To be in original container with label as dispensed by the pharmacy

Name of Medicine <i>(as described on the container)</i>	
Dosage	
Time to be given	
Are there any side effects that the School should know about?	
Who is responsible in an Emergency: different for off-site activities)	

I understand that I must deliver the medicine safely to **the school office.**

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to **appropriately trained** school staff administering medicine 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 medicine is stopped.

Date _____

Review date _____

Parent's Signature _____ Date _____

Headteacher's signature _____ Date _____

This will be reviewed at least annually or earlier if the child's needs change