REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

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| Students Full Name: | Tutor Group: |
| Address: | |
| Condition/ Illness: | Medication: |
| How long will student be required to take medication? | Is the medication prescribed by your GP?  YES/NO (Please delete accordingly) |
| Dosage required: | Frequency of Dosage: |
| Additional instructions/information:  (eg Before/after food, interaction with other medicines, possible side effects, storage) | |
| **I understand that I must deliver medicine personally, or send it with my child to the Medical Room, replace any used medication and collect any remaining medication when the course is completed. I accept that the school has the right to refuse to administer medication and that it is my responsibility to ensure that all medication is within expiry date and to inform the School of any medication changes.**  Name(Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **NB: Drugs/Medicines sent into School MUST be in current pharmacy-labelled containers.** | |