Request for Storage & Administration of Prescribed Medication

Pupil Details

Name of Child:		D.O.B:		Class:	

Condition / Illness:

Medication Details

Name / Type of Medication:	
For how long will your child take this medication?	
Storage Details:	

Directions for Use

Dosage & Method:	
Timing:	
Possible Side Effects?	

*I understand that the school is not **obliged** to give medication, but may do so on completion of this form and with the agreement of the Head of School.*

Signed:		Date:	
Print Name:		Relationship to Child	

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- I agree to my child *(insert name)* _____being administered the above medication
- I will immediately notify the school if there are subsequent changes to medicines or doses given.
- I will arrange for the medicine to be collected at the end of the day /course of medicine, by an appropriate adult (over 18 years).

Signature of Parent / Guardian:	
Signature of Head of School / Deputy HT:	
Date:	