CHILD MEDICATION REQUEST

Please complete this form if you are requesting a member of staff to administer medication during school hours. Medication will NOT be administered unless this form is returned to a senior manager. **Please note: wherever possible, the need for medicines to be administered at school should be avoided and therefore we ask parents to arrange the times of dosage accordingly.**

Medication must be in its original packaging with a dispensing label with the child's name clearly visible.

CHILD'S NAME/CLASS	
PARENT CONTACT NUMBER	
GP NAME/ADDRESS	
MEDICAL CONDITION	

Please tick one box:

My child will be responsible for the self-administration of medicine with supervision---- ☐

My child will require a member of staff to administer the medication---------- ☐

PARENT AUTHORISATION

As the parent I am responsible for the medicines being within the use-by date and the safe disposal of any medicines remaining after the treatment period or when the use-by date has passed.

As the parent I am responsible for ensuring sufficient medicine is stored at school to meet the required daily dosage during the time of treatment.

I verify that no other medicines are being taken at this time.

My child requires the following medication at school **as prescribed by a doctor**:

Name of medicine	Dose	Time	Start date	End date
Expiry date of medication				
Special instructions (if any)				
Allergies				

Signature (Parent) _____

Date _____