

Larwood Academy Trust



REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

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

DETAILS OF PUPIL

SURNAME: FORENAME:

ADDRESS:

M/F: DATE OF BIRTH:/...../..... CLASS/FORM:

CONDITION OR ILLNESS:

MEDICATION

NAME/TYPE MEDICATION:

(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: **YES / NO**

PROCEDURES TO TAKE IN AN EMERGENCY:

CONTACT DETAILS:

Name: Daytime Telephone No:

Relationship to Pupil:

Address:

I understand that I must deliver the medicine personally or give it to the taxi driver/escort and accept that this is a service which the school is not obliged to undertake.

Signature(s): Date:

Headteachers Signature: Date: