Request to Administer Medication Form

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

Name of Child: _____

Date of Birth: _____

Group/Class: _____

Medical condition/illness: _____

Medicine

Name and strength of Medicine (as described on the container): _____

Date dispensed: _____

Expiry date: _____

Dosage and method: _____

Timing: _____

Special Precautions / adaptations: _____

_____

Are there any side effects that the school/setting needs to know about? _____

Note: Medicines must be the original container as dispensed by the pharmacy

Contact Details

Name: _____

Daytime Telephone No: _____

Relationship to Child: _____

Address: _____

_____

I understand that I must deliver the medicine personally to a member of staff and accept that this is a service that the school is not obliged to undertake. The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy.

I understand that I must notify the school of any changes in writing.

Date: _____

Signature(s): _____

If more than one medicine is to be given a separate form should be completed for each one.