**Request for School to Administer Prescribed Medication**

The school will only give your child medicine that has been prescribed by a doctor and you have completed & signed the permission form. All Medicine must be in the original container as dispensed by the pharmacy with the child’s name & details on there and is in date.

Date: Click or tap for drop down menu.

Pupil Full Name:

Class: Click or tap here to enter text.

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| Name and Strength of Medicine (as written on the label): Click or tap here to enter text. |
| Expiry Date: Click or tap here to enter text. | Issue Date: Click or tap here to enter text. |
| How much to give (i.e. dosage to be given): Click or tap here to enter text. |
| When to be given: Click or tap here to enter text. |
| Quantity of medicinal items given to school: Click or tap here to enter text. |

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| Any additional information you think we may need to know: Click or tap here to enter text. |

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| Daytime contact number of parent/carer: Click or tap here to enter text. |
| Relationship to child: Click or tap here to enter text. |

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| Name of G.P/medical practice | Click or tap here to enter text. |
| G.P/medical practice phone number | Click or tap here to enter text. |

**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 will inform the school immediately if there is any change in dosage or frequency of the medication or if the medicine is stopped.**

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| Name of parent/carer: Click or tap here to enter text. | Signature:  |
| Relationship to child: Click or tap here to enter text. | Date: Click for drop down menu. |

**This section is for school use only**

Agreed by Senior Leader: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_