BIRCH COPSE SCHOOL

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(s): _____

Address: _____ M/F: _____

_____ DOB: _____

_____ Class: _____

Condition or illness: _____

MEDICATION:

Name/Type of medication (as described on the container): _____

For how long will your child take this medication: _____

Name and phone no. of prescribing GP: _____

FULL DIRECTIONS FOR USE:

Dosage and method: _____

Timing: _____

Special precautions: _____

Side effects: _____

Procedures to take in an emergency: _____

CONTACT DETAILS:

Name: _____ Phone no: _____

Relationship to Pupil: _____

Address: _____

I understand that I must deliver the medicine personally to a member of the school staff, and accept that this is a service which the school is not obliged to undertake.

Signed: _____ Date: _____

Relationship to Pupil: _____