Parental request for school administration of medicine
- please complete all areas

Name of child .... Date of birth............................

Class ....

Medical condition or illness ....

Please tick the appropriate box

My child will be responsible for the self-administration of medicines as directed below.

☐ **With supervision** ☐ **Without supervision**

☐ **I agree to members of staff administering medicines/providing treatment to my child as directed below.**

Name of Medicine	Dose	Frequency/times	Completion date of course (if known)	Expiry date of medicine
Special instructions				
Allergies				
Other prescribed medication child is taking at home				

Staffing (details of staff agreeing to the administration of this medication)

Name (1) ....

Name (2) ....

Parent Contact Details (<u>must be available for contact at all times</u>)

Name ....

Contact No/s ....

- I agree to update information about my child's medical needs held by the setting and that this information will be verified by GP and/or medical Consultant.
- I will ensure that the medicine held by the setting has not exceeded its expiry date.

NOTE: Where possible the need for medicines to be administered at the school should be avoided. Parents/Carers are therefore requested to try to arrange the timing of doses accordingly.

Date .... Signature(s) .... *parent/carer*

Print name...

<u>For completion by Headteacher</u>

I give my authorisation to the above request

This is valid for the period specified overleaf, or I wish this arrangement to be reviewed as necessary / on:

....

Headteacher's signature ....

Date ....