CHARFIELD PRIMARY SCHOOL

REQUEST TO ADMINISTER MEDICATION

Parents/guardians are advised that, unless you complete and sign this form the school will not administer medication to your son/daughter/ward. The Headteacher and staff must still agree to administer medication as this is a purely voluntary act on their part.

DETAILS OF PUPIL

Surname ____________________________ Forename(s) ______________________________

Home address____

Date of birth ________________________ Class _______________________________

CONDITION OR ILLNESS

Type of condition or Illness ____

Name & Type of Medication ____
(as described on container)

How long will your child require the medication? ____
(on going or specific time span)

FULL DIRECTIONS ON USE

Dosage & method ____
Timing ____
Special Precautions ____

CONTACT DETAILS

Name of Parent/Guardian ____
Address ____
Daytime Tel. No ____
Alternative Tel. No ____

I understand that I must personally deliver the medicine to the Head/Secretary/Class teacher and accept that this is a voluntary service provided by the school.

Signature of Parent/Guardian __________________________ Date __________________