MEDCIAL FORM 2

Form for parents to complete if they wish the school to administer medication or enable pupils to administer own medication

Pupil name: …….. Date of Birth: ……..

Name of Medication: ……

For how long will your child be taking this medication? ……

Condition or illness: ……..

Full directions for use:-

Dose and method: ……

Time of dose: (eg lunchtime) ……

Is your child going to self-administer: Yes / No (please circle)

Special Precautions: ……..

Side Effects: …….

Procedures to take in an emergency: ……

…….

……

Doctor's Details:

Doctor's Name: …….

Doctor's Address: ……

Doctor's Telephone: ……

I will deliver the medicine to my child's tutor, in the original packaging (with prescription details printed on).

I will inform the school if the medication changes.

Parent/Carer signature: …….. Date: ……

Heateacher signature: …….. Date: ……

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.