**MEDICAL FORM 2**

**Form for parents to complete if they wish the college 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: ………………………………

College Lead signature: …………………………………. Date: ………………………………

**THE COLLEGE WILL NOT GIVE YOUR CHILD MEDICINE UNLESS YOU COMPLETE AND SIGN THIS FORM, AND THE HEADTEACHER HAS AGREED THAT COLLEGE STAFF CAN ADMINISTER THE MEDICATION.**