



**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: .....

Heateacher 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.**