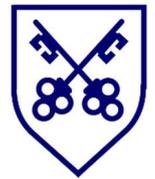


St Peter's C.E. Academy



REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Vice Principal has agreed that school staff can administer the medication.

DETAILS OF PUPIL:

SURNAME: _____

FORENAMES: _____

CLASS: _____

CONDITION OR ILLNESS: _____

MEDICATION:

NAME/TYPE OF MEDICATION: _____

(as described on the container)

HOW LONG WILL YOUR CHILDTAKE THIS MEDICATION:

DATE DISPENSED: _____

FULL DIRECTIONS FOR USE:

DOSAGE AND METHOD: _____

TIMING: _____

SPECIAL PRECAUTIONS: _____

SIDE EFFECTS: _____

PROCEDURES TO TAKEIN AN EMERGENCY: _____

CONTACT DETAILS:

NAME: _____ DAYTIME TELEPHONE NO: _____

RELATIONSHIP TO PUPIL: _____

ADDRESS: _____

I understand that I must deliver the medicine personally, labelled with my child's name and class, to a member of staff, and accept that this is a service which the school is not obliged to undertake.

Signature: _____ Date: _____