IRON ACTON CEVC PRIMARY SCHOOL
REQUEST TO ADMINISTER MEDICATION FORM

Parents/guardians are advised that, unless you complete and sign this form the school will not administer medication to your child. The Head teacher and staff must still agree to administer medication as this is a purely voluntary act on their part. The medicine must be on **prescription** only and needs to be taken during school hours. All medication will be stored in the staff kitchen in a container in the fridge. Staff will only administer prescription medicines as directed by the dispenser and in date.
This must be complete in black ink only

DETAILS OF PUPIL

Surname_________________________ Forename(s)___________________________

Date of Birth_______________________ Class ______________________________

CONDITION OR ILLNESS

Medical Condition or Illness ____
Name & Type of Medication(as described on container)___________________________
Date of expiry ____

How long will your child require the medication________________________________
(specific time span and date)

FULL DIRECTIONS ON USE

Dosage & Method ____

Timing____

Special Precautions____

Are there any side effects we need to know about________________________________

Procedures to take in an emergency____

CONTACT DETAILS
Name of Parent/Guardian____
Daytime Telephone Numbers ____
Relationship to the child ____
Address____

I understand that it is my responsibility to personally deliver the prescription medicine to School and accept that this is a voluntary service provided by the school.

Signature of Parent/Guardian __________________________ Date _____________

Date	Time given	Dose	Staff name	Text/call made

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