



## Request for the School to Administer Medication

The school will not give your child medicine unless you complete and sign this form and the Headteacher has agreed that the school staff can administer the medication. **Please sign the disclaimer overleaf.**

### DETAILS OF PUPIL

Surname: ..... Male/Female: .....

Forename(s): ..... Date of Birth: .....

Condition or illness: .....

### MEDICATION

Name/Type of Medication: .....  
(as described on the container)

Date dispensed: .....

### Full Directions for Use:

Dosage and method: .....

Timing: .....

Special Precautions: .....

Side Effects: .....

Self Administration: .....

Procedures to take in Emergency: .....

### CONTACT DETAILS

Name of Parent/Carer: ..... Daytime Tel: .....

Relationship to Pupil: .....

Address: .....

My child's doctor has prescribed the above medication. I understand that I must deliver the medication personally to an agreed member of staff. I accept that this is a service which the school is not obliged to undertake.

Signed: ..... Date: .....

Relationship to Pupil: .....



*I, the parent/guardian of the child named overleaf, request and give permission for the Headteacher, or person acting on his/her authority, to administer the above medication in accordance with the directions given. I understand that neither the Headteacher nor anyone acting on his/her authority, nor the Governing Body nor Suffolk County Council will be liable for any illness or injury to the child arising from the administering of the medicine or drug unless caused by the negligence of the Headteacher, the person acting on his/her authority, the Governing Body or Suffolk County Council, as the case may be.*

Signed: ..... Date: .....

Relationship to Pupil: .....