Request for Pupil to Administer Their Own Medication

DETAILS OF PUPIL

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

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

Address: ……………………………..……………………… Class: ……………………………….…………

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Condition or illness: ……………………………………………………………………………………………..

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Name of Medicine: …………………………………………………………….……………………………..

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Procedure to be taken in an emergency: ……………………………………………………………………….

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CONTACT INFORMATION

Name: ……….

Daytime 'Phone No: …………………………………………………………………………………………….

Relationship to Child: ……………………………………………………………………………………………...

I would like my son/daughter to keep his/her medication in school for use as necessary. 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 their administration of the medicine.

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

Relationship to Child: ……………………………………………………………………………………………...