

Holy Trinity Rosehill CofE Primary School

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not be able to administer medication to your child unless this form is completed and signed by a parent/carer.

DETAILS OF CHILD

Surname Forename(s)

Date of Birth Class Teacher

Address

.....

.....

Condition or illness.....

MEDICATION

Name/type of medication (as described on container).....

For how long will your child take this medicine.....

Date dispensed.....

Full directions for use:

Dosage and method.....

Time.....

Special precautions.....

Side effects.....

Self-administration.....

Procedures to take in an emergency.....

Does this medication need to be kept refrigerated.....

Arrangements for school visit.....

CONTACT DETAILS (please provide at least two phone numbers)

Contact 1 Name..... Daytime Tel

Relationship to pupil.....

Contact 2 Name..... Daytime Tel.....

Relationship to pupil.....

I understand that I must deliver the medicine personally to a representative of Holy Trinity Rosehill Primary School and accept that this is a service which the school is not obliged to undertake.

Signature(s)..... Date.....