

CHARFIELD PRIMARY SCHOOL

REQUEST TO ADMINISTER MEDICATION

Parents/guardians are advised that, unless you complete and sign this form the school will not administer medication to your son/daughter/ward. The Headteacher and staff must still agree to administer medication as this is a purely voluntary act on their part.

DETAILS OF PUPIL

Surname _____ Forename(s) _____

Home address _____

Date of birth _____ Class _____

CONDITION OR ILLNESS

Type of condition or Illness _____

Name & Type of Medication _____
(as described on container)

How long will your child require the medication? _____
(on going or specific time span)

FULL DIRECTIONS ON USE

Dosage & method _____

Timing _____

Special Precautions _____

CONTACT DETAILS

Name of Parent/Guardian _____

Address _____

Daytime Tel. No _____

Alternative Tel. No _____

I understand that I must personally deliver the medicine to the Head/Secretary/Class teacher and accept that this is a voluntary service provided by the school.

Signature of Parent/Guardian _____ Date _____