Parental Request for the Administration of Medication during School Hours

Child's Name: _____

Class: _____ DOB: _____

Home Address of Child: _____

Name and Address of GP: _____

_____ Tel No: _____

I would like to request that my child be administered medication as detailed with effect

from_____ to _____

I agree to abide by the school's policy on administering medication.

Parents Signature: _____

Date: _____ Contact No: _____

List of Prescribed Medicines

Brand Name and type of Medication	Strength	Dosage	Time between Doses	Date to commence

Please provide the date _____ and time _____ of the last dosage given.

Any other instructions: _____

Staff Use Only

For the member of staff taking these instructions: Please check the following:

- ☐ Have all the sections above been completed
- ☐ Does the medication bottle/pack have a prescription label from a pharmacy/dispensing chemist
- ☐ Check that the medication is a recent prescription
- ☐ Check that the medication is in date – advise parent if this medication is close to its expiry date
- ☐ Note if there any specific storage instructions for the medication

If you are happy to administer/supervise this medication, please sign and date this form below

Staff member_____ Date _____