ECCLESTON PRIMARY SCHOOL

Request for school to administer medication

Dear Parent,

Could you please complete this medication form to enable us to correctly administer your child's medication.

DETAILS OF PUPIL

Surname: _____
Forename(s) _____
Address: _____ M/F:
_____ Date of Birth:
_____ Class/Form:
Condition of illness: _____

MEDICATION

Name/Type of Medication (as described on the container) _____
For how long will your child take this medication: _____
Date dispensed: _____

Full Directions for use:

Dosage and method: _____
Timing: _____
Special Precautions: _____
Side Effects: _____
Self Administration: _____
Procedures to take in an Emergency: _____

CONTACT DETAILS:

Name: _____ Daytime Telephone No: _____
Relationship to Pupil: _____
Address: _____
_____

I give my permission for the school to administer the medication as outlined above.

Date: _____ Signature(s): _____

_____

Relationship to pupil: _____

ECCLESTON PRIMARY SCHOOL

Confirmation of the Head Teacher's agreement to administer medication

Dear Parents,

I agree that _____ will receive _____

every day at _____. _____ will be

supervised whilst he/she takes their medication by _____

This arrangement will continue until instructed by parents for this to cease.

Date: _____

Signed: _____