THAKEHAM PRIMARY SCHOOL
Rock Road, Storrington, West Sussex, RH20 3AA

REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you fully complete and sign this form and return it to the school office.

Details of Pupil

Surname _____ Forename _____

Address _____

_____

Date of Birth _____ Male/Female _____

Class _____ Teacher _____

Condition or illness _____

Medication

MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACY

Parents must ensure that in date properly labelled medication is supplied

Name/Type of medication (as described on the container)

Date dispensed _____

Expiry date _____

Full directions for use: Dosage and method

NB Dosage can only be changed on Doctor's instructions

Timing of dosage to be given at school _____

Special precautions/side effects _____

Procedure to take in an emergency

_____

_____

Contact details

Name _____

Phone number to be contacted _____

Relationship to pupil _____

Address if different to pupil

_____

_____

I understand that I must deliver the medication personally to a member of staff and accept that this is a service, which the school is not obliged to undertake. I understand that I must notify the school of any changes in writing.

Signature _____Date _____

GP Name _____Phone _____

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent's signature _____

Print name _____

Date _____

First Aider's Signature _____**Date** _____