Request for the school to administer **prescription** medication

The staff will not give your child **prescription** medicine unless you complete and sign this form, and the headteacher has agreed that the staff can administer the medication. Please read and sign the disclaimer below.

DETAILS OF PUPIL

Surname: …… M/F: ……

Forename(s): …… Date of Birth: ……

Address: ……

……

……

Condition or illness: ……

MEDICATION

Name/Type of Medication
(As described on the container) ……

……

Date dispensed: ……

Full directions for use: ……

Dosage and method: ……

Timing: **Please circle** 10.30 o'clock 12.00pm

Special precautions: ……

Side Effects: ……

Self-Administration: ……

Procedures to take in an Emergency: ……

CONTACT DETAILS:

Name of Parent/Carer: …… Daytime Phone No: ……

Relationship to pupil: ……

Address: ……

……

My child's doctor has prescribed the above medication. I understand that I must deliver the medication personally to an agreed member of staff. I accept that this is a service, which school staff are not obliged to undertake.

Signature: Date:

Relationship to pupil:

LEGAL DISCLAIMER

I understand that neither the headteacher nor anyone acting on his/her authority, nor the Governing Body, nor All Saints Schools Trust will be liable for any illness or injury to the child arising from the administering of the medication or drug unless caused by the negligence of the headteacher, the person acting on his/her authority, the Governing Body or All Saints Schools Trust as the case may be.

Signature: Date:

Relationship to pupil:

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			