**REQUEST FOR SCHOOL TO ADMINISTER MEDICATION**

The school will not give your child any medication unless you complete and sign this form and the Head Teacher has confirmed that a school staff member has agreed to supervise the administration of the medication.

**DETAILS OF PUPIL**

Surname …………………………………………………………………………………………………………………………………………….

Forename(s) …………………………………………………………………………………………………………………………………………….

Address …………………………………………………………… M/F …….……………………………………..

………………………………………………………………………… Date of Birth ……………………………………….

………………………………………………………………………… Class …………………………………………..

Condition or illness .................................................................................................................................................

**MEDICATION**

Name/Type of Medication (as described on the container, must be in the original packaging)

……………………………………………………………………………………………………………………………………………

For how long will your child take this medication

…………………………………………………………………………………………………………………………………………..

Date dispensed ……………………………………………………………………………………………………………………………………………

**FULL DIRECTION FOR USE**

Dosage and amount (as per instructions on container)

…………………………………………………………………………………………………………………………………………..