Request for school to administer medication

At Moat Farm Infant and Nursery School if it is necessary to give medication during the school day for the child's well-being we will be happy to assist.

The school will not give your child medication unless you complete and sign this form, and the Head Teacher has agreed that school staff can administer the medication.

Please note that non-prescribed medication should be limited to a 24 hour period and not exceed 48 hours. If symptoms persist seek medical advice.

Childs Surname:	Forename:
DOB:	Gender:
Address:	Allergies:
Year/Class:	Condition/Illness:

Medication Is the medication: - Prescribed ☐ Non-prescribed ☐

Name/Type of medication (as per dispensary label):	
For how long will your child take this medication:	
Date dispensed:	Expiry date:
Dosage (amount) and method of administration:	
Time(s) to be given:	
Special precautions (if any):	
Known side effects:	
Procedures to take in any emergency:	

Contact information

Family contact 1

Name:	
Home telephone number:	Work telephone number:
Relationship:	

Family contact 2

Name:	
Home telephone number:	Work telephone number:
Relationship:	

Parental agreement:

I understand that I must deliver the medicine personally to…… (name of staff member receiving medication, **class teacher**) and accept that this is a service which the school is not obliged to undertake.

Signature:	Date:
Name (print):	
Relationship:	

Confirmation of agreement for school to administer medication

I agree that (name of child)……Date of birth……

will receive (quantity and name of medicine)……

everyday at (time(s) medicine to be administered)……

Name of staff member to administer medication……

This will continue until (end date of the course of medicine)……

Authorised school signature:	
Position:	
Name (print):	Date:

Signature of Parent/carer:	
Relationship to child:	
Name (print):	Date:

A copy of this form should also be given to the parent/ carer.

Pupil medicine record

Name:	Date of birth:
Medicine name and type:	
Dosage and method of administration:	
Any known side effects to the medication?	
Timing:	
Name of administrator:	

Date	Time	Dosage	Administered by	Witnessed by	Comments	Parent signature	Medication returned? Y/N

*If medication is returned parents **must** sign to say they have received it.