Ramsgate Holy Trinity C.E. (Aided) Primary School

Request for school to administer medicine.

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

DETAILS OF PUPIL

Surname _____ Forename _____

Address _____

_____ Post Code _____

Male/Female Date of Birth _____ Class _____

Condition/Illness being treated. _____

MEDICATION

Name/Type of medication (as described on the packaging) Expiry Date _____

_____

_____

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 _____ Relationship to child _____

Day time phone number(s) _____

Address *if different from above*

_____

_____

I understand that I must deliver the medicine personally to the agreed member of staff and it is my responsibility to ensure medicine is returned as required. I accept that this is a service, which the school is not obliged to undertake.

Signed _____ **Parent/Guardian** **Date** _____