Hillmead Primary School

REQUEST FOR SCHOOL TO ADMINISTER PRESCRIPTION MEDICATION 2024-25

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

DETAILS OF PUPIL

Surname ……

Forename(s) ……

Address ……………………………………………………………………… ………………………………………………………………………

Date of birth ……………………………………………………………… Class ………………………………………………………………………

Condition or illness ………

MEDICATION

Name/Type of Medication ………………………………………………………………………………………………………
(as described on container)

For how long will your child take this medicine ……………………………………………………………………………

Date dispensed ……………………………………………………………………… Use by date: ……………………………………………

FULL DIRECTIONS FOR USE

Dosage and method ………

Timing ………

Special Precautions ………

Side Effects ……

Self Administration ………

Procedures to take in an Emergency …………………………………………………………………………………………

CONTACT DETAILS

Name …………………………………………………………… Daytime telephone no ………………………………………………………………

Relationship to Pupil …………………………………… Mobile telephone no ………………………………………………………………

Address ………

………

I understand that I must deliver the medicine personally to a member of office staff and accept that this is a service which the school is not obliged to undertake.

Signature ……………………………………………………………………………………………… Date …………………………