LONGWELL GREEN PRIMARY SCHOOL
REQUEST TO ADMINISTER MEDICATION

Parents/guardians are advised that, *unless you complete and sign this form the school will not administer medication to your child. The Headteacher and staff must still agree to administer medication as this is a purely voluntary act on their part.*

Name of Child:	Class:
Home Address:	Date of Birth:
Name of Condition or Illness:	Date Medication Commenced:
Name & Type of Medication Prescribed:	How long will your child require the medication? (ongoing or specific time span)
Dosage & Method	Time(s) to be administered:
Special Precautions: (ie before food)	

CONTACT DETAILS

Name of Parent/Carer _____ Contact Telephone Number _____

- ***I understand that an adult must deliver and collect the medicine to/from the School Office which must be provided in original packaging with a spoon and a pharmacy label attached. (Antibiotics only need to come into School if required 4 times per day.)***
- ***I accept that this is a voluntary service provided by the school.***

Signature of Parent/Carer _____ Date _____

Medication received in school			**Medication collected from school**		
DATE	Parent/Carer Signature	Staff Signature	DATE	Parent/Carer Signature	Staff Signature

For office use only:

Date	Time	Dosage Given	Signature