CAPEL-LE-FERNE PRIMARY SCHOOL

Request for School to Administer Medication

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

Pupils Name:……

Date of Birth ……Male/Female……..

Name of medicine (as described on container)
……Date dispensed……

How long will child take medicine:

Dosage and method: (i.e. self administration)

Timing:

Special precautions/Side Effects/Precautions to take:

Contact Details Name ……
Address …….
Relationship to Pupil: …….. ..Tel: No:…….

I request that the above medication be given in accordance with the above information by a responsible member of the school staff.
I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.
I understand that I must deliver the medicine personally to members of the office staff in properly labelled containers with child's name on and accept that this is a service which the school is not obliged to undertake.
I understand that the school staff may not be able to administer the medication at the time specified.
I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent and will not be held personally responsible in anyway and that the school staff may need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

Signature(s) ……..Date: …….
Parent / Guardian

Confirmation of Head Teacher's agreement to administer medicine:

I agree …… will receive medication as directed. He/she will be given/supervised whilst taking the medication by a member of staff. This arrangement to continue until either end of course or until instructed by parent.

Signature …….Date…….
Head Teacher

Date	Time	Dosage	Reactions	Signed	Staff Name