Ashbeach School

Request for school to administer medicine

Details of pupil

Name ____ Date of Birth ___________________

Address ____

Class/Form ______________________

Condition or illness ____

I consent to my child receiving the following medication in school

Name of medication (on prescription) ____

Date dispensed _________________________Expiry date ________________________

Dosage _________________________ Time of dose __________________________

Side effects ____

Self Administration ____

How long will your child need this medication ____________________________________

I will supply sufficient medication and equipment as necessary.

I will ensure the medicines are prescribed by a doctor and are labelled with my child's details.

I understand the information on this form will be shared by relevant staff.

I understand that staff will volunteer to administer medicine and that they are not contractually obliged to do so. They will record the dose and note any side effects.

I have seen the schools Managing Medicines policy

Contact Details

Name _______________________________________ Daytime phone no. __________________

Relationship to Pupil ____

Address ____

Signed ____ Date __________________