CALVERLEY CE PRIMARY SCHOOL

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Details of Pupil

Surname _____

Forename _____ Gender Male / Female

Address _____ Date of birth _____

_____ Class _____

Post code _____

Condition or Illness _____

Medication

Name of Medication _____

How many days is the medication to be given for. _____ / ____daily_____

Directions

Dosage and Method _____

Timing _____

Notes _____

Contact Details

Name _____ Daytime telephone number _____

Relationship to pupil _____

Address (if not the one above) _____

_____

The school will not give your child medication unless you have completed and signed this form. Staff will not administer the medicine but will supervise the taking of the medicine in line with the details on this form.

By signing I agree to these arrangements and absolve the school of any responsibility for any adverse reactions the child may have to the medication and from my child refusing to take the medication.

Please Note – Medication will be given before lunch unless otherwise stated.

Signature of parent. …… Date ……