Feniscowles Primary School
Request for Administration of Medication

The school will not give your child medicine unless you complete and sign this form, and a member of the Senior Leadership Team has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Full Name _____

Address _____M/F _____

_____Date of Birth_____

_____Year/Class _____

Condition or Illness _____

MEDICATION

Name/Type of Medication (as described on the container) _____

For how long will your child take this medication _____

Date dispensed _____

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 _____

Address _____

I understand that I must deliver the medicine personally to a member of staff and the medicine must be collected by an adult, and accept that this is a service which the school is not obliged to undertake.

Date _____ Signature _____

Relationship to Pupil _____