ST THOMAS OF CANTERBURY CATHOLIC 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 the school staff can administer the medication.
NB: Medicines must be in the original container as dispensed by the pharmacy

DETAILS OF PUPIL

Name of Child _____

Date of Birth _____

Class _____

Medical condition or illness _____

MEDICATION

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

Date dispensed _____/_____/_____

Expiry Date _____/_____/_____

Dosage and method _____

Timing _____

Special precautions _____

Are there any side effects that
school need to know about? _____

Self-administration Yes/No (delete as appropriate)

Procedures to take in an emergency _____

CONTACT DETAILS

Name _____

Daytime Telephone No _____

Relationship to pupil _____

I accept that this is a service which the school is not obliged to undertake. I also understand that the school may at times either overlook or be unable to administer the prescribed medication. I understand that I must notify the school of any changes in writing.

Date _____/_____/_____ Signature(s) _____

Record of medicine administered to an individual child

Date	Time Given	Dose Given	Name of Staff Member	Staff Initials