MED 1 FORM

REQUEST FOR SCHOOL TO ADMINSTER MEDICATION

He school will not give your child medicine unless you complete and sign this form, and the headteacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Surname					
Forename					
Address					
Date of birth		**Class**		**M/F**	

Condition or illness	

MEDICATION

Name /Type of Medication (as described on the container)	
For how long will the child take this medication	
Date dispensed	

FULL DIRECTION OF USE

Dosage and method	
Timing	
Special Precautions	
Side effects	
Self administration	
Procedures to take in an emergency	

CONTACT DETAILS

Name		**Telephone No**	
Relationship to pupil			
Address (If different from above)			

I understand that I must deliver the medicine personally to (agreed member of staff) and accept that this is a service which the school is not obliged to undertake.

Date **Signature**