HORNBY ST MARGARET'S C OF E PRIMARY SCHOOL
PARENTS AND CARERS - ADMINISTRATION OF MEDICINE

The school will not give your child any medication unless you complete and sign this form and the Headteacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Surname: _____

Forename(s): _____

Condition or illness: _____

MEDICATION

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

For how long will your child take this medication: _____

Date dispensed:

Prescribed medicine / Over the counter:

FULL DIRECTIONS FOR USE:

Dosage and amount (as per instructions on container): _____

Method: _____

Timing: _____

Special Precautions: _____

Side Effects: _____

Storage Instructions: _____

Procedures to take in an Emergency: _____

CONTACT DETAILS:

Name: _____ Daytime Telephone No: _____

Relationship to Pupil: _____

Address: _____

_____

I understand that I must deliver the medication personally to the OFFICE and accept that this is a service which the school is not obliged to undertake.

Date: _____ Signature(s): _____

_____

Relationship to pupil: _____

Medication Record Form

Child's Name

.....

Medication	Dose	Time	Date	Signature 1	Signature 2