

### PARENT/CARER REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

Name:	M/F	DOB:	Form:
Condition or illness (e.g. asthma, diabetes, Cystic Fibrosis, Anaphylaxis, recovery from illness, etc.)			
Doctor's Name:	Medical Practice:		Tel. No.
Name of medication:			
Type of medication (e.g. tablets, liquid, inhaler, EpiPen, etc.)			
Date dispensed:		Dosage and method:	
Times to be taken in school:		Is precise timing critical? Yes/No	
For how long will your child need to take this medication?			
For medication that need not be administered at pre-set times please indicate when it should be given (e.g. before exercise, onset of asthma attack, onset of migraine, etc.)			
The medication needs to be administered by a member of staff			YES    NO
My child is capable of administering the medication him/herself under the supervision of a member of staff			YES    NO
I would like my child to keep his/her medication on him/her for use as necessary			YES    NO
The medication needs to be readily accessible in case of emergency			YES    NO
Precautions or side effects:			
What would you like us to do in an emergency?			
Emergency contact telephone: Home: Work: Mobile			
The doctor named above has advised that it is necessary for my child to receive his/her medication during school time. I understand that teachers have no <i>obligation</i> to give or supervise the administration of medicines at school. However, I request that the medication named above be administered by/taken under supervision of a member staff, who may not have had any first aid or medical training. The school, the Headteacher and staff accept no responsibility for any injury, death or damage suffered by a pupil as a result of the administration of medicine mentioned in this form, other than any injury, death or damage which arises because the school or any members of its staff have been negligent. I shall arrange to collect and dispose of any unused, expired medicine at the end of each term.			
Parent/Carer signature:			
Date:			